

90 13001

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

QHMH:16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Elmer N. Mariner | | 2. DATE OF DEATH MONTH 4 - DAY 12 - YEAR 90 | | 3. TIME OF DEATH 8:15a. | |
| 4. SOCIAL SECURITY NUMBER 705-09-8111 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 92 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) 09-26-97 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9. FACILITY NAME (If not institution, give street and number) Edw.W.McCready Memorial Hospital | |
| 10a. STATE Maryland | | 10b. COUNTY Somerset | | 10c. CITY, TOWN OR LOCATION OF DEATH Crisfield | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 417 Charlotte Ave. | | 10f. ZIP CODE 21817 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 8 College (1-4 or 5+) - - | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Crane Operator | | 16b. KIND OF BUSINESS/INDUSTRY Brass & Copper Works | | 17. FATHER'S NAME (First, Middle, Last) Albert G. Mariner | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Gutridge | | 19a. INFORMANT'S NAME (Type/Print) Rachel T. Mariner | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 a b c d e f | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Sunnyridge Memorial Park | | 20c. LOCATION — City or Town, State Crisfield, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Rachel T. Mariner | | 22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons, Main St., Crisfield, Md. 21817 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septicemia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { a. DUE TO (OR AS A CONSEQUENCE OF): Septicemia b. DUE TO (OR AS A CONSEQUENCE OF): Subcutaneous ulcers c. DUE TO (OR AS A CONSEQUENCE OF): Shard Area and d. DUE TO (OR AS A CONSEQUENCE OF): Robberson Area | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 4/12/90 | |
| 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED McCreedy Tugboat | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) McCreedy Tugboat | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M. D. Barhan | | 29c. LICENSE NUMBER 12764 | | 29d. DATE SIGNED (Month, Day, Year) 4/12/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. M. D. Barhan, Rt. #413, Crisfield, Md. 21817 | | 31. DATE FILED (Month, Day, Year) APR 19 '90 | | 32. REGISTRAR'S SIGNATURE J. Davidson-Randall | |

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BALTIMORE, MD



BOX 13146,

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OF VITA

DIVISION

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Maryland

08-26-27

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USA

21217

417 Charlotte Ave.

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Brass & Copper Works

Machine Operator

Grade 8

Amos Sutcliffe

Albert E. Farmer

James as a b c d e f

Rachel T. Farmer

Christiana, MD

Surryville Memorial Park

04-12-20

21217

90 13003

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

REG. NO.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page 6 may be retained by the hospital or attending physician.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Russell Curtis Merriken | | | | 2. DATE OF DEATH MONTH DAY YEAR 4-26-90 | | 3. TIME OF DEATH 9:00PM M | |
| 4. SOCIAL SECURITY NUMBER 218-60-6094 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 28 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 26, 1961 | |
| 9a. FACILITY NAME (If not institution, give street and number) 9300 Berryman Lane | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Reisterstown | | 9c. COUNTY OF DEATH Baltimore County | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Randallstown | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 8937 Church Lane | | | | 10f. ZIP CODE 21133 | | 10g. CITIZEN OF WHAT COUNTRY? USA. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY Auto Repair | | | |
| 17. FATHER'S NAME (First, Middle, Last) Richard C. Merriken, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Randall | | | |
| 19a. INFORMANT'S NAME (Type/Print) Rhonda Merriken | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8937 Church Lane, Randallstown, Md. 21133 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Memorial Park | | 20c. LOCATION — City or Town, State Eldersburg, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. L. ...</i> | | | | 22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel Owings Mills, Md. 21117 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries with compression asphyxia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Scene | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 4-26-90 | | 28b. TIME OF INJURY 7:30PM | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED Driver in auto/auto impact | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 9300 Berryman Lane, Baltimore County, Maryland | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 4-27-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frank Peretti, MD 111 Penn street, Baltimore, MD 21201 VC | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 30 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be used for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Pamela Pearl McCoy | | | | 2. DATE OF DEATH MONTH DAY YEAR 4-24-90 | | 3. TIME OF DEATH 8:35AM M | |
| 4. SOCIAL SECURITY NUMBER 217-88-6498 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 26 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8-31-63 | |
| 9a. FACILITY NAME (If not institution, give street and number) Carroll County General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Westminster | | 9c. COUNTY OF DEATH Carroll County | |
| 10a. STATE MD | | 10b. COUNTY Carroll | | 10c. CITY, TOWN OR LOCATION Hampstead | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 841 South Main Street | | | | 10f. ZIP CODE 21074 | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY n/a | | | |
| 17. FATHER'S NAME (First, Middle, Last) Clyde Willis | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lacy Looney | | | |
| 19a. INFORMANT'S NAME (Type/Print) Terry McCoy | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 841 S. Main Street, Hampstead, MD 21074 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation Services | | 20c. LOCATION — City or Town, State Hampstead, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert K. Pritts, Sr. | | | | 22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia complicating fatty liver DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Julia Goodin, MD | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 4-25-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julia Goodin, MD 111 Penn Street, Baltimore, MD 21201 vc | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 30 '90 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MD 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be used for hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) GEORGE GARFIELD MARSH | | | | 2. DATE OF DEATH MONTH DAY YEAR APRIL 29, 1990 | | 3. TIME OF DEATH 4:51 P M | |
| 4. SOCIAL SECURITY NUMBER 214 05 7008 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 28, 1911 VA | |
| 9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND, MARYLAND | | 9c. COUNTY OF DEATH ALLEGANY | |
| 10a. STATE MD | | | | 10b. COUNTY Allegany | | 10c. CITY, TOWN OR LOCATION Cumberland | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1530 Apt F. Old Towne Manor | | 10f. ZIP CODE 21502 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: white | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) owner & operator | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Gulf Service Station | | | | 16b. KIND OF BUSINESS/INDUSTRY Gulf Service Station | | 17. FATHER'S NAME (First, Middle, Last) Barbour Marsh | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucy Margaret Grigsby | | | | 19a. INFORMANT'S NAME (Type/Print) Mrs. Margarite V. Marsh | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1530 Apt F Old Towne Manor Cumberland, MD 21502 | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Sunset Memorial Park | | 20c. LOCATION — City or Town, State Cumberland, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F Scapelli | | | | 22. NAME AND ADDRESS OF FACILITY Scapelli Funeral Home Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Severe sepsis DUE TO (OR AS A CONSEQUENCE OF): CHF II - D DUE TO (OR AS A CONSEQUENCE OF): Renal failure DUE TO (OR AS A CONSEQUENCE OF): Blindness Approximate Interval Between Onset and Death 3 days | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John Mehanua M.D. | | | | 29c. LICENSE NUMBER D-17526 | | 29d. DATE SIGNED (Month, Day, Year) 4-30-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN MEHANUA, M.D. 909-B SETON DRIVE CUMBERLAND, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 02 1990 | | 32. REGISTRAR'S SIGNATURE John Mehanua | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13007

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN DAYTON MUDGE | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 3, 1990 | | 3. TIME OF DEATH 8:00 A M | |
| 4. SOCIAL SECURITY NUMBER 214-07-2065 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-17-1918 MD | |
| 9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | | 9c. COUNTY OF DEATH Allegany | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE WV | | 10b. COUNTY Mineral | | 10c. CITY, TOWN OR LOCATION Wiley Ford | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER Box 18 | | | | 10f. ZIP CODE 26767 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 Elementary Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) down twist dept. | | 16b. KIND OF BUSINESS/INDUSTRY textile | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Harrison Mudge | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jesse Captolia | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Shirley M. Mudge | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 18 Wiley Ford, WV 26767 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Rosedale Funeral Chapel | | 20c. LOCATION — City or Town, State Martinsburg, WV | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli | | | | 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): b. Lung atelectasis / pleural effusion DUE TO (OR AS A CONSEQUENCE OF): c. CHF / ESRD DUE TO (OR AS A CONSEQUENCE OF): d. Restrictive lung disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER K. Suresh | | | | 29c. LICENSE NUMBER D31579 | | 29d. DATE SIGNED (Month, Day, Year) 5/3/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. K. Suresh 517 Old Town Rd. Cumberland, Maryland 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 04 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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90 13008

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ALVIN FRIEDRICH MOSER | | | | 2. DATE OF DEATH MONTH DAY YEAR May 3, 1990 | | 3. TIME OF DEATH 7:00 p.m. | |
| 4. SOCIAL SECURITY NUMBER 170-18-4853 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MARCH 6 1906 | |
| 8. BIRTHPLACE (State or Foreign Country) GERMANY | | | | 9a. FACILITY NAME (If not institution, give street and number) Cumberland Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | |
| 9c. COUNTY OF DEATH Allegany | | | | 10a. STATE MARYLAND | | | |
| 10b. COUNTY ALLEGANY | | | | 10c. CITY, TOWN OR LOCATION FLINTSTONE | | | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER BOX# 42 | | | |
| 10f. ZIP CODE 21530 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ELECTRICAL - PALMAR CORP. | | 16b. KIND OF BUSINESS/INDUSTRY ELECTRICAL | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAKOB MOSER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) GEBORENE PERRETH | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARYBELLE MOSER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOX# 42 FLINTSTONE, MARYLAND 21530 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ROSEDALE CREMATORY | | 20c. LOCATION — City or Town, State MARTINSBURG, W.VA. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dale L. Merritt | | | | 22. NAME AND ADDRESS OF FACILITY SILCOX-MERRITT FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiovascular Arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Carcinomatosis b. Metastatic Disease c. Myocardial Infarction d. Stroke | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. T. Williams |
| 29c. LICENSE NUMBER D 16041 | | | | | | | 29d. DATE SIGNED (Month, Day, Year) MAY 3-90 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. T. Williams, Memorial Hospital Medical Building, Cumberland, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 04 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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90 13009

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Edna W. Myers | | | | 2. DATE OF DEATH MONTH 5 DAY 5 YEAR 90 | | 3. TIME OF DEATH 11:30AM | |
| 4. SOCIAL SECURITY NUMBER 218-24-8289 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 88 YRS. | 7. DATE OF BIRTH MONTH 09 DAY 29 YEAR 1901 | 8. BIRTHPLACE (State or Foreign Country) PA | | |
| 9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland Md | | 9c. COUNTY OF DEATH Allegany | |
| 10a. STATE Md | | | | 10b. COUNTY Allegany | | 10c. CITY, TOWN OR LOCATION Cumberland | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 119 E Elder | | | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ret. bookkeeper | | 16b. KIND OF BUSINESS/INDUSTRY Vandergrift Music Shop | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edwin S. Willison | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Estelle Morgart | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Anna L. Vandergrift | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bedford Road Cumberland, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Odd Fellows Cemetery | | 20c. LOCATION — City or Town, State Flintstone, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpill | | | | 22. ADDRESS OF FUNERAL HOME Scarpill Funeral Home Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Renal failure Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Hypertension b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Post operative hip repair for Fx hip 4/1/90 | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 4/1/90 | | 28b. TIME OF INJURY AM | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify) Memorial Hosp. | | 28e. DESCRIBE HOW INJURY OCCURRED Patient fell in hospital Rm | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Paul Snow, M.D. Dpty Med. Ex | | 29c. LICENSE NUMBER D 09157 | | 29d. DATE SIGNED (Month, Day, Year) 5/5/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Snow, M.D. Dpty Med. Ex 124 W 3rd St Cumb Md 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 07 1990 | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13010

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) SOPHIA Mary MORRISON | | | | 2. DATE OF DEATH MONTH DAY YEAR May 6, 1990 | | 3. TIME OF DEATH 2:25 A M | |
| 4. SOCIAL SECURITY NUMBER 215-10-0971 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-11-1910 MD | |
| 9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | | 9c. COUNTY OF DEATH Allegany | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Allegany | | 10c. CITY, TOWN OR LOCATION Cumberland | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER P.O. Box 1245 | | | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary Secondary (9-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) housewife | | 16b. KIND OF BUSINESS/INDUSTRY own home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Papsha | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary (nmn) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Edgar B. Morrison, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1245 Cumberland, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Rocky Gap Veterans Cemetery | | 20c. LOCATION — City or Town, State Flintstone, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jones & Scarpelli | | | | 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiopulmonary arrest Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Constrictive Heart Failure Myocardial infarction Coronary atherosclerosis | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER D25296 | | 29d. DATE SIGNED (Month, Day, Year) 5/6/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Crossland 53 Greene Street Cumberland, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 08 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01081 00

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/89

11031 00

90 13012

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary Irene Merryman | | | | 2. DATE OF DEATH MONTH DAY YEAR April 24 1990 | | 3. TIME OF DEATH 5:00 A^M | |
| 4. SOCIAL SECURITY NUMBER 577-01-8771 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 01/27/07 | |
| 9a. FACILITY NAME (If not Institution, give street and number) AMI DRS' HOSPITAL OF PG COUNTY | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Lanham | | 9c. COUNTY OF DEATH Prince George | |
| 10a. STATE Maryland | | | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Hyattsville | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 7759 Emerson Road | | | |
| 10f. ZIP CODE 20784 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) NONE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Henry F. King | | | | 15. MOTHER'S NAME (First, Middle, Maiden Surname) Clara R. Dorr | | | |
| 19a. INFORMANT'S NAME (Type/Print) Robert C. Ingwersen | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12221 Rolling Hill Lane, Bowie, Maryland 20715 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Resurrection Cemetery | | 20c. LOCATION — City or Town, State Clinton, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): c. Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): d. Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic Stenosis | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 25a. DATE OF INJURY (Month, Day, Year) | | 25b. TIME OF INJURY M | | 25c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25d. DESCRIBE HOW INJURY OCCURRED | | 25e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 25f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER D12015 | | 29d. DATE SIGNED (Month, Day, Year) 4-24-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Louis Steinberg 6492 Landover Rd Landover Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 27 '90 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be used for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

30 13015

90 13013

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last) Linwood Lee Marable | | | | 2. DATE OF DEATH MONTH DAY YEAR April 24 1990 | | 3. TIME OF DEATH HOURS MINUTES 2:45 | |
| 4. SOCIAL SECURITY NUMBER 578-05-8990 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 04/04/08 | |
| 8a. FACILITY NAME (If not institution, give street and number) Leland Memorial Hospital | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Riverdale | | 8c. COUNTY OF DEATH Prince George's | |
| 9. RESIDENCE OF DECEASED | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George's | |
| 10c. CITY, TOWN OR LOCATION Bladensburg | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 4931 56th Place | |
| 10f. ZIP CODE 20710 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) 12 | | | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Railroad Engineer | | 16b. KIND OF BUSINESS/INDUSTRY Pennsylvania Railroad | |
| 17. FATHER'S NAME (First, Middle, Last) (Unavailable) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Marton Baker | | | |
| 19a. INFORMANT'S NAME (Type and Print) Ed Thompson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5901 Mount Eagle Drive, #214, Alexnadria, VA 22303 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery | | 20c. LOCATION — City or Town, State Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Dis. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER 109925 | | 29d. DATE SIGNED (Month, Day, Year) April 24, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John S. Rogers, M.D. 1919 Seminary Road, Silver Spring, Maryland 20901 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 27 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be filled in as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified of and examined the deceased.

30 13013

90 13014

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Anatolio D. Matiga | | | | 2. DATE OF DEATH MONTH DAY YEAR 4- 24 1990 | | 3. TIME OF DEATH 10:10 A M | |
| 4. SOCIAL SECURITY NUMBER 219-84-9794 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 86 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 7-3-03 | | 8. BIRTHPLACE (State or Foreign Country) Philippines | |
| 9a. FACILITY NAME (If not institution, give street and number) 505 Beech Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Fort Washington | | 9c. COUNTY OF DEATH Prince Georges | |
| 10a. STATE Maryland | | 10b. COUNTY Prince Georges | | 10c. CITY, TOWN OR LOCATION Fort Washington | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 505 Beech Street | | | | 10f. ZIP CODE 20744 | | 10g. CITIZEN OF WHAT COUNTRY? Philippine Islands | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Filipino | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Purchasing Agent | | 16b. KIND OF BUSINESS/INDUSTRY Government of Philippines | | | |
| 17. FATHER'S NAME (First, Middle, Last) Servando M. Matiga | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Teresa Q. Dalmao | | | |
| 19a. INFORMANT'S NAME (Type/Print) Narcisa L. Matiga | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Beech St. Fort Washington, Md. 20744 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. LOCATION — City or Town, State Alexandria, Virginia | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. <i>Cardiac pulmonary arrest</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. <i>Cerebral vascular accident</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. <i>Arterio Sclerotic Cardiovascular Disease</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Insulin dependent Diabetes Mellitus</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D17162 | | 29d. DATE SIGNED (Month, Day, Year) 4/25/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Linda Whithy MD 9556 CRAIN Hwy UPPER MARLBORO, MD 20772 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 26 '90 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be used for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the attending physician and completely filled in by the funeral director, prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

00 13010

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UNKNOWN 90-50

90 13015

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Darrylle Mahoney | | | | 2. DATE OF DEATH MONTH DAY YEAR 4-6-90 | | 3. TIME OF DEATH 7:00AM M | |
| 4. SOCIAL SECURITY NUMBER 579-82-7375 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 27 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-31-62 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington, DC | | 9a. FACILITY NAME (If not institution, give street and number) 7319 Timberwood Drive-street | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | 9c. COUNTY OF DEATH Montgomery County | |
| 10a. STATE D.C. | | | | 10b. COUNTY Washington | | 10c. CITY, TOWN OR LOCATION Washington | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1320 Fairmont Street, N.W. #202 | | | |
| 10f. ZIP CODE 20009 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unemployed | | 16b. KIND OF BUSINESS/INDUSTRY N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last) Teddy Moore | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Mahoney | | | |
| 19a. INFORMANT'S NAME (Type/Print) Catherine Mahoney | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1320 Fairmont Street, NW #202 Wash. D.C. 20009 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park | | 20c. LOCATION — City or Town, State Landover, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY W.H. Bacon Funeral Home 3447 14th Street, N.W. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Gunshot wound of head Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) SCENE | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 4-6-90 | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED Subject shot | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Street, in front of-- | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 7319 Timberwood Dr., Silver Spring, Maryland | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | 29b. LICENSE NUMBER OCME |
| 29c. DATE SIGNED (Month, Day, Year) 4-6-90 | | | | | | | 29d. SIGNATURE AND TITLE OF CERTIFIER |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANK PERETTI, MD 111 Penn Street, Baltimore, MD 21201 VC | | | | | | | 31. DATE FILED (Month, Day, Year) APR 24 '90 |
| 32. REGISTRAR'S SIGNATURE | | | | | | | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 must be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it must be attached to the body of the deceased.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31221 02

REG. NO.

DHMH-1A Rev. 1/89




TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 13019

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Grant B. Names, Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR 4-22-90 | | 3. TIME OF DEATH 1:07PM M | |
| 4. SOCIAL SECURITY NUMBER 215-44-1528 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 44 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8-29-45 | |
| 8. BIRTHPLACE (State or Foreign Country) New York | | | | 9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie | |
| 9c. COUNTY OF DEATH Anne Arundel County | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Arnold | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 848 Mago Vista Road | | | | 10f. ZIP CODE 21012 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Vietnam | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Airline Pilot | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Air | | | |
| 17. FATHER'S NAME (First, Middle, Last) Grant B. Names, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Lewis | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Sheena W. Names | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 S. Washington St. #722E Alexandria, VA 22314 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY 495 Ritchie Highway Barranco & Sons Severna Park, MD 21146 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 4-22-90 | | 28b. TIME OF INJURY 11:55AM | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED Driver in auto/auto impact | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) Hammonds Ferry Road, Anne Arundel County, Maryland | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER  | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 4-24-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita A. Korell, M.D. | | | | 111 Pern Street, Baltimore, MD 21201 | | | |
| 31. DATE Filled (Month, Day, Year) APR 27 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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the first day of 1977

90 13018

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|---|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) THOMAS C. NORRIS | | 2. DATE OF DEATH MONTH 4 DAY 21 YEAR 90 | | 3. TIME OF DEATH 1445 M |
| 4. SOCIAL SECURITY NUMBER 216-12-0727 | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (in yrs. last birthday) 74 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 5-7-15 | |
| 8a. FACILITY NAME (If not institution, give street and number) Carroll County General Hospital | | 8b. CITY, TOWN OR LOCATION OF DEATH Westminister | | 8c. COUNTY OF DEATH Carroll |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE Md. | 10b. COUNTY Carroll | 10c. CITY, TOWN OR LOCATION Taneytown | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 10e. STREET AND NUMBER 5131 Babylon Road | | 10f. ZIP CODE 21787 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 year | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Orthotist | | 16b. KIND OF BUSINESS/INDUSTRY Brace Shop |
| 17. FATHER'S NAME (First, Middle, Last) Carl Norris | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Capps | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Claire Norris | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5131 Babylon Rd., Taneytown, Md. 21787 | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Stewart W. Eline | | 22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 934 S. Main St., Hampstead, Md. 21074 | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RESPIRATORY FAILURE Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE OLD TUBERCULOSIS | | | | Approximate Interval Between Onset and Death YRS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER MS Kaye MD | | 29c. LICENSE NUMBER D29246 | 29d. DATE SIGNED (Month, Day, Year) 4-21-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) N. PASPARA MD 217 Washington Hts - Westminster MD 21157 | | | | |
| 31. DATE FILED (Month, Day, Year) APR 24 '90 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13019

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Leroy James Nelson | | | | 2. DATE OF DEATH MONTH DAY YEAR 4 6 90 | | 3. TIME OF DEATH 11:20 A^M | |
| 4. SOCIAL SECURITY NUMBER 192-26-5185 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5/27/10 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9. CITY, TOWN OR LOCATION OF DEATH Salisbury, Md. | | 10. COUNTY OF DEATH Wicomico County | |
| 11. FACILITY NAME (If not institution, give street and number) Salisbury Nursing Home | | | | 12. STATE Virginia | | 13. COUNTY Accomack | |
| 14. STREET AND NUMBER Rt. 638 | | | | 15. ZIP CODE 23417 | | 16. CITY, TOWN OR LOCATION Onancock | |
| 17. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 18. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES W.W. II | | 19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | |
| 20. RACE — American Indian, Black, White, etc. Specify: White | | | | 21. DECEDENT'S EDUCATION (Specify only highest grade completed) 11 | | 22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Navy | |
| 23. KIND OF BUSINESS/INDUSTRY | | | | 24. FATHER'S NAME (First, Middle, Last) James Nelson | | 25. MOTHER'S NAME (First, Middle, Maiden Surname) Addie Lawson Nelson | |
| 26. INFORMANT'S NAME (Type/Print) Gene Byrd | | | | 27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1834 Clachan Ct.- Vienna Va. 22182 | | | |
| 28. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 29. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery | | 30. LOCATION — City or Town, State Arlington, Va. | |
| 31. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Tom Williams</i> | | | | 32. NAME AND ADDRESS OF FACILITY P.O. Box 218 Williams Onancock F.H. Onancock, Va. 23417 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Emphysema</i> DUE TO (OR AS A CONSEQUENCE OF): SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i>Congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 26. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 27. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 28. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 29. DATE OF INJURY (Month, Day, Year) | | 30. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 31. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 32. DESCRIBE HOW INJURY OCCURRED | | | |
| 33. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 34. SIGNATURE AND TITLE OF CERTIFIER <i>William Robins</i> | | | |
| 35. LICENSE NUMBER D29349 | | | | 36. DATE SIGNED (Month, Day, Year) 4/6/91 | | | |
| 37. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Robins, M.D., 1104 Healthway Drive, Salisbury, Md. 21801 | | | | | | | |
| 38. DATE FILED (Month, Day, Year) APR 12 90 | | | | 39. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary T. Newman | | 2. DATE OF DEATH APRIL 19, 1990 YEAR | | 3. TIME OF DEATH 1:50 AM | |
| 4. SOCIAL SECURITY NUMBER 577-20-5101 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | |
| 7. DATE OF BIRTH 2-6-21 | | 8. BIRTHPLACE (State or Foreign) MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 2404 BRIGHTSEAT ROAD #T2 | | 9b. CITY, TOWN OR LOCATION OF DEATH LANDOVER | | 9c. COUNTY OF DEATH PRINCE GEORGE'S | |
| 10a. STATE MARYLAND | | 10b. COUNTY PRINCE GEORGE'S | | 10c. CITY, TOWN OR LOCATION LANDOVER | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2404 BRIGHTSEAT ROAD #T2 | | 10f. ZIP CODE 20785 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COOK | | 16b. KIND OF BUSINESS/INDUSTRY FOOD SERVICE | |
| 17. FATHER'S NAME (First, Middle, Last) ALTON PROCTOR | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSELLA NEWMAN | | | |
| 19a. INFORMANT'S NAME (Type/Print) CARL J. NEWMAN, Sr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2404 BRIGHTSEAT ROAD #T2 LANDOVER, MARYLAND 20785 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND NATIONAL PARK | | 20c. LOCATION — City or Town, State LAUREL, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FUNERAL HOME ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASH. D.C. 20019 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic Squamous Cell Ca of the Neck</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>COPD</u> | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER D31528 | | 29d. DATE SIGNED (Month, Day, Year) 4/24/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2308 Dodge Park Road Landover MD 20785 | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 26 '90 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 should be filed with the hospital or attending physician. Page 4 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



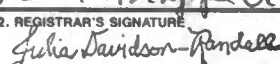
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--------------------------|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Eleanor R. Nafz | | | | 2. DATE OF DEATH MONTH DAY YEAR 4 29 90 | | 3. TIME OF DEATH 5:50 A M | |
| 4. SOCIAL SECURITY NUMBER 224-60-3074 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03-7-04 | |
| 8. BIRTHPLACE (State or Foreign Country) Ohio | | | | 9a. FACILITY NAME (If not institution, give street and number) Calvert Manor Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH Rising Sun | |
| 9c. COUNTY OF DEATH Cecil | | | | 10a. STATE Maryland | | 10b. COUNTY Hartford | |
| 10c. CITY, TOWN OR LOCATION Aberdeen | | | | 10d. INSIDE CITY LIMITS? YES 2 NO | | 10e. STREET AND NUMBER 1004 Waewick Dr. Apt. 24 | |
| 10f. ZIP CODE 21001 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary Analyst | | 16b. KIND OF BUSINESS/INDUSTRY Dept. of Interior | |
| 17. FATHER'S NAME (First, Middle, Last) Galen Rhodes | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Smith | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sane Gervasoni | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Philadelphia Ave. Abingdon, Md. 21009 | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) R. A. Ferris & Company | | 20c. LOCATION — City or Town, State West Chester, Pa. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSÉE  | | | | 22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. ABERDEEN, MARYLAND 21001-3399 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. COPD, Severe | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. ASCVD | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. Hypothyroidism | | | | | | | |
| Approximate Interval Between Onset and Death 2 days 10 yr 10 yr 10 yr | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | |
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 YES 2 NO | | | |
| 28c. INJURY AT WORK? 1 YES 2 NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER 109482 | | 29d. DATE SIGNED (Month, Day, Year) 4/30/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Duane Phillips 2017 Trappe Rd Box 500 Darkington Md 20034 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 01 '90 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Leander M Morris Tayson | | | | 2. DATE OF DEATH MONTH 5 DAY 1 YEAR 90 | | 3. TIME OF DEATH 755 A M | |
| 4. SOCIAL SECURITY NUMBER 218-18-7869 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5 2 24 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Fallston General Hosp. | | 9b. CITY, TOWN OR LOCATION OF DEATH Fallston | |
| 9c. COUNTY OF DEATH Harford | | | | 10a. STATE Maryland | | 10b. COUNTY Harford | |
| 10c. CITY, TOWN OR LOCATION Bel Air | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 2248 Allibone Road | |
| 10f. ZIP CODE 21014 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist | | 16b. KIND OF BUSINESS/INDUSTRY Manufacturing | | | |
| 17. FATHER'S NAME (First, Middle, Last) Clinton Morris Tayson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Euna Lee Shotwell | | | |
| 19a. INFORMANT'S NAME (Type/Print) Bessie A. Tayson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2248 Allibone Road, Bel Air, Md. 21014 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Tabor U. M. Cemetery | | 20c. LOCATION — City or Town, State Bel Air, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Howard K. McComas III | | | | 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pulmonary Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Metastatic Lung Carcinoma PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Dante Monakill MD | | 29c. LICENSE NUMBER 20764 | |
| 29d. DATE SIGNED (Month, Day, Year) 5/1/90 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DANTE MONAKILL MD | | 31. DATE FILED (Month, Day, Year) MAY 01 '90 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Handwritten text, possibly a signature or date, located in the center of the page.

Handwritten text at the bottom of the page, possibly a date or reference number.

90 13023

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) EVELYN OFFUTT | | | | 2. DATE OF DEATH MONTH DAY YEAR April 16, 1990 | | 3. TIME OF DEATH 10:35A | |
| 4. SOCIAL SECURITY NUMBER 579-05-1382 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-3-1921 | |
| 9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Olney | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE MD | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION OLNEY | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 17703 Caotbridge Plave | | | | 10f. ZIP CODE 20832 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 7 College (13-16 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeper | | 16b. KIND OF BUSINESS/INDUSTRY Bureau Of Standard | | | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) AVA OFFUTT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17703 Caotbridge Pl. Olney MD | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) PARKLAWN CEMETERY | | 20c. LOCATION — City or Town, State Rockville MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY MODERN FUNERAL HOME 382114th ST.N.W.D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → INTRACEREBRAL HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF): MALIGNANT HYPERTENSION Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST SUBARACHNOID HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF): ATHEROSCLEROTIC HEART DISEASE AORTIC VALVE REPLACEMENT DICATED CAUSO MYOPATHY | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATHEROSCLEROTIC HEART DISEASE AORTIC VALVE REPLACEMENT DICATED CAUSO MYOPATHY | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 36822 | | 29d. DATE SIGNED (Month, Day, Year) 04/19/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David Grossberg, M.D. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 20 '90 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13024

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Roger Leon Obitts</u> | | | | 2. DATE OF DEATH MONTH <u>4</u> DAY <u>7</u> YEAR <u>90</u> | | 3. TIME OF DEATH <u>2340</u> M | |
| 4. SOCIAL SECURITY NUMBER <u>219-36-4534</u> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (in yrs. last birthday) <u>50</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>Apr. 21, 1939</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Washinton County Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Hagerstown</u> | | 9c. COUNTY OF DEATH <u>Washington</u> | |
| 10a. STATE <u>Maryland</u> | | | | 10b. COUNTY <u>Washington</u> | | 10c. CITY, TOWN OR LOCATION <u>Williamsport</u> | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER <u>117 W. Salisbury St.</u> | | | | 10f. ZIP CODE <u>21795</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>7</u> College (1-4 or 5+) <u></u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Maintenance</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>Refridgeration</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>John William Obitts</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mary Isabell Shives</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Mary I. Obitts</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>117 W. Salisbury St. Williamsport, MD 21795</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Riverview Cemetery</u> | | 20c. LOCATION — City or Town, State <u>Williamsport, MD 21795</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Mary M. Davis</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>OSBORNE FUNERAL HOMES</u> <u>P.O. Box # 348 Williamsport, MD 21795</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cardiorespiratory failure</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <u>Respiratory failure</u> b. <u>Chronic emphysema</u> c. <u>Chronic heart disease</u> d. <u>Chronic hypertension</u> | | | | | | | Approximate Interval Between Onset and Death <u>35</u> <u>23 hr</u> <u>?</u> <u>8</u> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Richard S. Oakley</u> | | | | 29c. LICENSE NUMBER <u>D1248</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>4-8-90</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Richard S. Oakley</u> <u>303 W. Memorial Blvd Wc</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>APR 11 90</u> | | | | 32. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1950 10

2052
ITEMS:23,27 per ME G-665
7-17-90 cm

90 13025

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Nathan Keith O'Claire | | | | 2. DATE OF DEATH MONTH DAY YEAR 4-29-90 | | 3. TIME OF DEATH 5:50AM M | | | | | |
| 4. SOCIAL SECURITY NUMBER N/A | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) YRS. MONTHS DAYS 8 3 | | 7. DATE OF BIRTH (Month, Day, Year) Sept 29, 1989 | | 6. BIRTHPLACE (State or Foreign Country) Penn. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Hospital of Cecil County | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Elkton | | | 9c. COUNTY OF DEATH Cecil County | | | | |
| 10a. STATE Md. | | 10b. COUNTY Cecil | | 10c. CITY, TOWN OR LOCATION North East | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 258 Willard st. | | | | 10f. ZIP CODE 21901 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A | | | 16b. KIND OF BUSINESS/INDUSTRY N/A | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Clayton J. O'Claire | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Domni J. Johnson | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Clayton J. O'Claire | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 258 Willard St. North East, Md. 21901 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) R.A. Ferris & Co. Crematory | | | 20c. LOCATION — City or Town, State West Chester, Pa. | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edward McKown | | | | 22. NAME AND ADDRESS OF FACILITY Gee Funeral Home 259 E MAIN ST ELKTON, MD. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → TRAUMATIC CEREBRAL ARTERY ANEURYSM COMPLICATIONS OF CEREBRAL ANEURYSM DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SPINAL CORD COMPRESSION | | | | | | | | Approximate interval Between Onset and Death | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) NOVEMBER 1990 | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT IN MOTOR VEHICLE COLLISION | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) UNKNOWN | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) UNKNOWN | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 4-30-1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Mario F. Golle, Jr. MD 111 Penn Street, Baltimore, MD 21201 | | | | | | | | 31. DATE FILED (Month, Day, Year) MAY 09 1990 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Pondale | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be completed by the medical examiner.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

90 13026

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Michael NMN O'Loughlin | | | | 2. DATE OF DEATH MONTH DAY YEAR 4 29 90 | | 3. TIME OF DEATH 400 A M | |
| 4. SOCIAL SECURITY NUMBER 110-07-4279 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3/3/11 | |
| 9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Harve de Grace | | 9c. COUNTY OF DEATH Harford | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Belcamp | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4603 A Annhurst Drive | | | | 10f. ZIP CODE 21017 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Military | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Army Officer | | | |
| 17. FATHER'S NAME (First, Middle, Last) Samuel O'Loughlin | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Marie UNK | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Virginia O'Loughlin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4603 A Annhurst Drive, Belcamp, Md. 21017 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Spesutia Cemetery | | 20c. LOCATION — City or Town, State Perryman, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Md. 21001-3399 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. ACUTE RENAL FAILURE | | | | Approximate Interval Between Onset and Death 10 DAYS | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | b. CONGESTIVE HEART FAILURE | | | | 4 YRS | |
| | | c. | | | | | |
| | | d. | | | | | |
| | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARDIAC CIRRHOSIS | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER William MD | | | | 29c. LICENSE NUMBER D 32609 | | 29d. DATE SIGNED (Month, Day, Year) 4/30/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KAMRUD IN K MITTANI 433 GARARD ST HARVE DE GRACE, MD 21078 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 01 '90 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the hospital or attending physician.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13027

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN CECIL PANNELL | | | | 2. DATE OF DEATH MONTH DAY YEAR APRIL 16 1990 | | 3. TIME OF DEATH P M 1:00 P | |
| 4. SOCIAL SECURITY NUMBER 232-24-8175 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) SEP 5 1922 | |
| 8. BIRTHPLACE (State or Foreign Country) VIRGINIA | | | | 9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA | |
| 9c. COUNTY OF DEATH MONTGOMERY | | | | 10a. STATE DISTRICT OF COLUMBIA | | 10b. COUNTY COLUMBIA | |
| 10c. CITY, TOWN OR LOCATION Washington | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 178 DARRINGTON STREET, SW | |
| 10f. ZIP CODE 20032 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES 1943-1969 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) U. S. A. F. | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DEFENSE | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) TYLER PANNELL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ZERATA ROBERTSON | | | |
| 19a. INFORMANT'S NAME (Type/Print) IVA M. PANNELL, 178 DARRINGTON STREET, SW, WASHINGTON, DC 20032 | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlington National Arlington Virginia | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National | | 20c. LOCATION — City or Town, State Arlington Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>E. M. Dudley</i> | | | | 22. NAME AND ADDRESS OF FACILITY Dudley, S Fun Home 3200 Rhode Ave Mt Rainier, MD | | | |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC PANCREATIC CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>H. F. Meyers</i> MD | | | | 29c. LICENSE NUMBER G049409 (CA) | | 29d. DATE SIGNED (Month, Day, Year) APR 17, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) H. F. MEYERS, LCDR, MC, USN | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NATIONAL NAV AL MEDICAL CENTER BETHESDA, MD 20814-5011 | | | |
| 31. DATE FILED (Month, Day, Year) APR 18 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2017/1/10

2017/1/10

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Edna Phillips | | | | 2. DATE OF DEATH MONTH DAY YEAR 4-12-90 | | 3. TIME OF DEATH 4:30 PM | |
| 4. SOCIAL SECURITY NUMBER 579-03-0330-B | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-26-18 | |
| 8. BIRTHPLACE (State or Foreign Country) West Va. | | | | 9a. FACILITY NAME (If not institution, give street and number) 10710 Phillips Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH Upper Marlboro | |
| 9c. COUNTY OF DEATH P.G. | | | | 10a. STATE Md. | | 10b. COUNTY P.G. | |
| 10c. CITY, TOWN OR LOCATION Upper Marlboro | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 10710 Phillips Drive | | | | 10f. ZIP CODE 20772 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Forrest M. Underwood | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) May V. Simms | | | |
| 19a. INFORMANT'S NAME (Type/Print) Forst J. Phillips | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10710 Phillips Dr., Upper Marlboro, Md. 20772 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lee Crematory | | 20c. LOCATION — City or Town, State Clinton, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Maryland 20735 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Metastatic Breast Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <u>18 months</u> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension, Decubitus</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D24945 | | 29d. DATE SIGNED (Month, Day, Year) APRIL 13, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7801 OLD BRANCH AVE #409 CLINTON, MD 20735 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 19 '90 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

05081 02

90 13029

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Perry, Clarence A. Jr.</u> | | | | 2. DATE OF DEATH MONTH <u>04</u> DAY <u>20</u> YEAR <u>90</u> | | 3. TIME OF DEATH <u>8:30 A.M.</u> | |
| 4. SOCIAL SECURITY NUMBER <u>215-44-8399</u> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>57</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>11-5-32</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>HOLY CROSS HOSPITAL</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>SILVER SPRING</u> | | 9c. COUNTY OF DEATH <u>PGC</u> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <u>D.C.</u> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <u>WASHINGTON</u> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <u>5020 13th ST. N.E.</u> | | | | 10f. ZIP CODE <u>20017</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>4YRS</u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>THCHNICIAN</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>H.U.D.</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Clarence Perry</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>CECIL E. DOUGLASS</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Joan Perry (wife)</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5020 13th ST N.E. WASH.D.C. 20017</u> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>James E. Williams</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>THE HOUSE OF WILLIAMS</u> <u>3821 14th ST. N.W.</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>cerebellar pontine infarct</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Ischemic cerebrovascular disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death <u>3 weeks</u> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE NOW INJURY OCCURRED | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | 29b. DATE SIGNED (Month, Day, Year) <u>4/20/90</u> |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Suzanne P. Burns MD</u> | | | | 29c. LICENSE NUMBER <u>D37273</u> | | 29d. DATE SIGNED (Month, Day, Year) | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>1011 North Capitol St. Washington, DC 20002</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>APR 23 '90</u> | | | | 32. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) BERNICE Caho PISTOLAS | | | | 2. DATE OF DEATH MONTH DAY YEAR APRIL 18 90 | | 3. TIME OF DEATH 6:00 P M | |
| 4. SOCIAL SECURITY NUMBER 577-18-8707 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 08/09/13 | |
| 9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGE'S HOSPITAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY | | 9c. COUNTY OF DEATH PRINCE GEORGE'S | |
| 10a. STATE Maryland | | | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Cheverly | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 6421 Landover Road, Apt. #201 | | | | 10f. ZIP CODE 20785 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) ----- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | 16b. KIND OF BUSINESS/INDUSTRY P.G. County Govt. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Morgan Pistolas | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Mann | | | |
| 19a. INFORMANT'S NAME (Type/Print) Robert Holden, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1 Box 1A, Grasonville, Maryland 21638 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) George Washington Cemetery | | 20c. LOCATION — City or Town, State Adelphi, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Francis Gasch</i> | | | | 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septilemia DUE TO (OR AS A CONSEQUENCE OF): Peritonitis DUE TO (OR AS A CONSEQUENCE OF): Perforated gastric ulcer DUE TO (OR AS A CONSEQUENCE OF): Corticosteroid therapy Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER HALUK BONEVAL M.D. | | 29c. LICENSE NUMBER D04238 | | 29d. DATE SIGNED (Month, Day, Year) 4.19.90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HALUK BONEVAL, M.D. 6001 LANDOVER ROAD, CHEVERLY, MD. 20785 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 23 '90 | | 32. REGISTRAR'S SIGNATURE <i>Julian Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HOWARD EDWARD PARKER | | | | 2. DATE OF DEATH MONTH 4 DAY 24 YEAR 90 | | 3. TIME OF DEATH 1120 M | |
| 4. SOCIAL SECURITY NUMBER 242-26-3060 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 64 YRS. | 7. DATE OF BIRTH (Month, Day, Year) Apr. 3, 1926 | | 8. BIRTHPLACE (State or Foreign Country) North Carolina | |
| 9a. FACILITY NAME (If not institution, give street and number) Fairfield Nursing Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Crownsville | | 9c. COUNTY OF DEATH Anne Arundel | |
| 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Edgewater | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 505 Overhill Drive | | | | 10f. ZIP CODE 21037 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W W II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager | | 16b. KIND OF BUSINESS/INDUSTRY Sales | | | |
| 17. FATHER'S NAME (First, Middle, Last) John W. Parker | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie | | | |
| 19a. INFORMANT'S NAME (Type/Print) Wesley Parker | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Overhill Drive, Edgewater, MD 21307 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery | | 20c. LOCATION — City or Town, State Crownsville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert S. Taylor</i> | | | | 22. NAME AND ADDRESS OF FACILITY Taylor Funeral Chapel 147 Gloucester St., Annapolis, MD 21401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory arrest | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): Ca lung | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael J. Lapenta</i> | | | | 29c. LICENSE NUMBER D 21438 | | 29d. DATE SIGNED (Month, Day, Year) 4.24.90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL J. LAPENTA MD 600 RINGLEY AVE #120, ANNAP 21401 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 25 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Gordon-Rosen</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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90 13032

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Richard James Phoenix | | | | 2. DATE OF DEATH MONTH 4 DAY 18 YEAR 1990 | | 3. TIME OF DEATH 10:00 A. M | |
| 4. SOCIAL SECURITY NUMBER 017-32-0739 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 48 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-3-1942 | |
| 9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Annapolis | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1030 F Spa Road | | | | 10f. ZIP CODE 21403 | | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman | | 16b. KIND OF BUSINESS/INDUSTRY Automobile | | | |
| 17. FATHER'S NAME (First, Middle, Last) Ernest M. Phoenix | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Leda Larochele | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Leda Phoenix | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Avenue Uxbridge, Massachusetts 01569 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Prospect Hill Cemetery | | 20c. LOCATION — City or Town, State Uxbridge, Massachusetts | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael P Marzullo | | | | 22. NAME AND ADDRESS OF FACILITY Marzullo Funeral Service 3981 Carrollton Road Upperco, Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MALIGNANT CARDIAC ARRHYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. ATHEROSCLEROTIC CARDIOMYOPATHY b. INSULIN DEPENDENT DIABETES c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC METABOLIC ACIDOSIS | | | | | | | Approximate Interval Between Onset and Death |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Paul T. Barbera MD RESIDENT | | | | 29c. LICENSE NUMBER D37708 | | 29d. DATE SIGNED (Month, Day, Year) 04.18.90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) - Same - | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 23 '90 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be used for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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90 13033

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Charles E. Poole | | | | 2. DATE OF DEATH MONTH DAY YEAR 4 - 18 - 90 | | 3. TIME OF DEATH 1530 | |
| 4. SOCIAL SECURITY NUMBER 212-70-1918 | | 6. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 5. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6-14-14 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) CARROLL CO. General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Westminster | |
| 9c. COUNTY OF DEATH CARROLL | | | | 10a. STATE md | | 10b. COUNTY CARROLL | |
| 10c. CITY, TOWN OR LOCATION Sykesville | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 7309 Second Ave | |
| 10f. ZIP CODE 21784 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) — | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FARM WORKER | | 16b. KIND OF BUSINESS/INDUSTRY Farming | |
| 17. FATHER'S NAME (First, Middle, Last) UNKNOWN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print) Carroll County Dept. on Aging | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, MD 21157 | | | |
| 20a. MANNER OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Springfield Cemetery | | 20c. LOCATION — City or Town, State Sykesville, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian A. Haight | | | | 22. NAME AND ADDRESS OF FACILITY Haight Funeral Home P.O. Box 195 Sykesville, MD. 21784 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac arrest or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): Acute Hepatic Failure | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): Urosepsis | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): Incontinence Foley Catheter | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. (1) NIDDM (2) CHF (3) PACEMAKER | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Thomas Galvin MD | | | | 29c. LICENSE NUMBER P31660 | | 29d. DATE SIGNED (Month, Day, Year) 4/18/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS GALVIN MD 542 WASHINGTON RD WESTMINSTER MD 21157 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 23 90 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It must be signed by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

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90 13034

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mae E. Proctor | | | | 2. DATE OF DEATH MONTH DAY YEAR April 15, 1990 | | 3. TIME OF DEATH 9:45 a.m. | |
| 4. SOCIAL SECURITY NUMBER 220 32 5073 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5/4/'23 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Southern MD Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Clinton | |
| 9c. COUNTY OF DEATH Prince George's | | | | 10a. STATE Maryland | | 10b. COUNTY Charles | |
| 10c. CITY, TOWN OR LOCATION Malcolm | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER Route 1 Box 288 | |
| 10f. ZIP CODE 20613 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) James Robert Thompson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosie Ella Proctor | | | |
| 19a. INFORMANT'S NAME (Type/Print) Carlos Proctor | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Star Rte Box 5 Leonardtown, MD 20650 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St Peter's Church Cem. | | 20c. LOCATION — City or Town, State Waldorf, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martell Adams | | | | 22. NAME AND ADDRESS OF FACILITY Adams Funeral Home, P.A. Aguasco Road, Aguasco, MD 20608 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE AND CHRONIC RESPIRATORY FAILURE Approximate Interval Between Onset and Death DAYS. | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST SEVERE END STAGE OF EMPHYSEMA MONTHS. | | | | | | | |
| Hepato-renal failure days. | | | | | | | |
| atherosclerotic coronary heart disease. years. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of theophylline toxicity, disseminated intravascular coagulopathy, hypercholesterolemia, severe peripheral arterial occlusive disease | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Peter W. Yim | | | | 29c. LICENSE NUMBER D12884 | | 29d. DATE SIGNED (Month, Day, Year) APRIL 16 '90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER W. YIM M.D. 7900 OLD BRANCH AVE. SUITE 101, CLINTON, MARYLAND 20735 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 26 '90 | | | | 32. REGISTRAR'S SIGNATURE Lelia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It is to be signed by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 13036

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13035

| | | | | | | | | |
|--|--|---|--|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Margaret Virginia Parker | | | | 2. DATE OF DEATH MONTH 4 DAY 24 YEAR 90 | | 3. TIME OF DEATH 3:30 P M | | |
| 4. SOCIAL SECURITY NUMBER 212-24-2876 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs, last birthday) 97 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 09-26-92 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Pleasant View Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Mt. Airy | | 9c. COUNTY OF DEATH Carroll | | |
| 10a. STATE Maryland | | 10b. COUNTY Howard County | | 10c. CITY, TOWN OR LOCATION Cooksville | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER Millers Mill Road | | | | 10f. ZIP CODE 21723 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) ? College (1-4 or 6+) ? | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Domestic | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John T.R. Dorsey | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Frances Barnes | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Paul Parker | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3317 Stapleton Dr. Glenwood, MD 21738 | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Parker Family Cemetery | | 20c. LOCATION — City or Town, State Cooksville, MD | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Harry W. Haight | | | | 22. NAME AND ADDRESS OF FACILITY Haight Funeral Home (P.O. Box 195) Sykesville, MD 21784 (301)-795-1400 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral vascular accident DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Cerebral Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): Cerebral Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate interval Between Onset and Death | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ascens, Dehydration, Anemia, arthritis | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Mevin J Kordon MD | | | | 29c. LICENSE NUMBER 006788 | | 29d. DATE SIGNED (Month, Day, Year) 4/25/90 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mevin J Kordon MD 2000 Century Plaza Columbia MD 21044 | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 1 '90 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) CONCELLO V. PARKER | | | | 2. DATE OF DEATH MONTH DAY YEAR APRIL 19 1990 | | 3. TIME OF DEATH 0128 M | |
| 4. SOCIAL SECURITY NUMBER 215-12-6881 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2/7/03 | |
| 8. FACILITY NAME (If not institution, give street and number) Peninsula General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Salisbury, MD | | 9c. COUNTY OF DEATH Wicomico | |
| 10a. STATE Maryland | | 10b. COUNTY Wicomico | | 10c. CITY, TOWN OR LOCATION Parsonsborg | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER Parsonsborg Melson Rd. P.O. Box 35 | | | | 10f. ZIP CODE 21849 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) House Wife | | 16b. KIND OF BUSINESS/INDUSTRY None | | | |
| 17. FATHER'S NAME (First, Middle, Last) James West | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Beatrice West | | | |
| 19a. INFORMANT'S NAME (Type/Print) Beatrice Parker | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 35 Parsonsborg Melson Rd. Md. 21849 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Glass Hill Cemetery | | 20c. LOCATION — City or Town, State Parsonsborg, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladys B. Stewart | | | | 22. NAME AND ADDRESS OF FACILITY Clinton F. Stewart Salis. Md. 21801 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiopulmonary arrest with brain damage Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Cardiomyopathy b. DUE TO (OR AS A CONSEQUENCE OF): Hypertension c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Bladys B. Stewart | | | | 29c. LICENSE NUMBER D17181 | | 29d. DATE SIGNED (Month, Day, Year) 4/19/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bal Agarwal 614C Eastern Shore drive Salisbury, md. 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 20 '90 | | 32. REGISTRAR'S SIGNATURE John A. Anderson | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 13037

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ALFRED J. PHARES | | | | 2. DATE OF DEATH MONTH DAY YEAR 4-27-90 | | 3. TIME OF DEATH 5 PM M | |
| 4. SOCIAL SECURITY NUMBER 234-62-4568 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 50 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-7-39 | |
| 8. BIRTHPLACE (State or Foreign Country) WV | | | | 9a. FACILITY NAME (If not institution, give street and number) Garrett Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Oakland | |
| 9c. COUNTY OF DEATH Garrett | | | | RESIDENCE OF DECEDENT | | | |
| 10a. STATE WV | | 10b. COUNTY Grant | | 10c. CITY, TOWN OR LOCATION Maysville | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER Rt 3, Box 77 | | | | 10f. ZIP CODE 26833 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Coal Miner | | 16b. KIND OF BUSINESS/INDUSTRY Douglas Coal Company | | | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Macie Phares | | | |
| 19a. INFORMANT'S NAME (Type/Print) Naomi Phares | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt 3, Box 77 Maysville, WV 26833 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Burgess Family Cemetery | | 20c. LOCATION — City or Town, State Maysville, WV | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kevin S. Schaeffer</i> | | | | 22. NAME AND ADDRESS OF FACILITY SCHAEFFER FUNERAL HOME INC 11 North Main Street-P.O. Box 455 Petersburg, WV 26847 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Lung Carcinoma (metastatic-etiology uncertain) | | | | | |
| | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| Cirrhosis of the liver secondary to alcohol abuse | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| Coagulopathy with intestinal bleeding -- secondary to the cirrhosis | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Other | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Karl E. Schwalm</i> MD | | | | 29c. LICENSE NUMBER D27205 | |
| | | | | 29d. DATE SIGNED (Month, Day, Year) 4/27/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KXXX Karl E. Schwalm 311 N. 4th St., Oakland, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 10 1990 | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

00 13031

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|--|--|---|--|---|--|----------|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CLARA COTER | | | | 2. DATE OF DEATH MONTH DAY YEAR April 19, 1990 | | | | 3. TIME OF DEATH 10:45 PM | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 061-16-4414 | | | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1/05/09 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Peninsula General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Salisbury, MD | | | | 9c. COUNTY OF DEATH Wicomico | | | | | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Wicomico | | 10c. CITY, TOWN OR LOCATION Nanticoke | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER Nutters Road / P. O. Box 67 | | | | 10f. ZIP CODE 21840 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Afro-American | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 7th grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) housekeeper - domestic | | 16b. KIND OF BUSINESS/INDUSTRY Private Families | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Coter | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Liza (unknown) | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) John A. Pinder | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as above / 21840 | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Green Acres Memorial Park | | 20c. LOCATION — City or Town, State Salisbury, MD | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia Jolley Lashley</i> | | | | 22. NAME AND ADDRESS OF FACILITY Jolley Memorial Chapel Rt. #2, Box 920, Jersey Rd, Salis., MD 21801 | | | | | | | | | | | |
| 23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Cardiopulmonary arrest DUE TO (OR AS A CONSEQUENCE OF): b. severe cor pulmonale DUE TO (OR AS A CONSEQUENCE OF): c. severe pulmonary fibrosis DUE TO (OR AS A CONSEQUENCE OF): d. congestive Heart failure | | | | | | | | Approximate Interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ignatius L. D. Nardo M.D.</i> | | | | 29c. LICENSE NUMBER D31546 | | 29d. DATE SIGNED (Month, Day, Year) 4/19/90 | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ignatius L. D. Nardo M.D. P.O. Box 680 Prince Georges Anne, MD | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 23 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. Pinder</i> | | | | 21853 | | | | | | | |

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Shepard Sebastian Pearson, Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR 4 29 90 | | 3. TIME OF DEATH M 6:30AM | |
| 4. SOCIAL SECURITY NUMBER 217-14-1798 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7 6 08 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 201 St. Mark Way Apt. 409 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Westminster | | 9c. COUNTY OF DEATH Carroll | |
| 10a. STATE Maryland | | | | 10b. COUNTY Carroll | | 10c. CITY, TOWN OR LOCATION Westminster | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 201 St. Mark Way | | | | 10f. ZIP CODE 21157 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W W II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 5+ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) banker | | 16b. KIND OF BUSINESS/INDUSTRY banking | |
| 17. FATHER'S NAME (First, Middle, Last) Shepard S. Pearson, Sr. | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Lombard | | | |
| 19a. INFORMANT'S NAME (Type/Print) Elizabeth F. Pearson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 St. Mark Way Westminster, MD 21157 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Anatomical Board of Maryland | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin D. Hartzler</i> | | | | 22. NAME AND ADDRESS OF FACILITY D.D. Hartzler & Sons New Windsor, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. CONGESTIVE HEART FAILURE b. ASVD c. d. Approximate Interval Between Onset and Death 24 Apr 90 | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Res. Jan - CLV | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dean H. Griffin MD</i> | | | | 29c. LICENSE NUMBER 24278 | | 29d. DATE SIGNED (Month, Day, Year) 4-29-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dean H. Griffin 19 Ridge Rd. Westminster, MD 21157 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 30 '90 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1, 2, and 3 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be consulted.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROY EVERS PAYNE | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 - 04 - 1990 | | | | 3. TIME OF DEATH 6:00 P.M. | |
| 4. SOCIAL SECURITY NUMBER 219038721 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7. DATE OF BIRTH (Month, Day, Year) 11/21/1908 | | | | 8. BIRTHPLACE (State or Foreign Country) West Virginia | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | | | | 9c. COUNTY OF DEATH ALLEGANY COUNTY | |
| 10a. STATE Maryland | | | | 10b. COUNTY Allegany | | 10c. CITY, TOWN OR LOCATION Cumberland | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 949 Seton Drive, Apt. #2 | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary (0-12) High School (13-14) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ret. conductor & brakeman | | 16b. KIND OF BUSINESS/INDUSTRY B&O Railroad | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edward R. Payne | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Susan Bishop | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Wanna E. Payne | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 949 Seton Dr. Apt. #2 Cumberland, MD 21502 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Sunset Memorial | | 20c. LOCATION — City or Town, State Cumberland, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Scarpelli</i> | | | | 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death years years | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease Diabetes mellitus | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas J. DeLino</i> | |
| 29c. LICENSE NUMBER D21488 | | | | 29d. DATE SIGNED (Month, Day, Year) 5-5-90 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 55 Jackson St., Coraoking, NJ 21539 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 07 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13041

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) LARRY J PARKER | | | | 2. DATE OF DEATH MONTH DAY YEAR 4 23 90 | | 3. TIME OF DEATH 3:15 PM | |
| 4. SOCIAL SECURITY NUMBER Unknown | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 38 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05-17-51 | |
| 9a. FACILITY NAME (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CLINTON | | 9c. COUNTY OF DEATH PRINCE GEORGES | |
| 10a. STATE Maryland | | | | 10b. COUNTY Temple Hills | | 10c. CITY, TOWN OR LOCATION Temple Hills | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3012 Brinkley Road, #T2 | | | |
| 10f. ZIP CODE 20748 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clinical Psychologist | | 16b. KIND OF BUSINESS/INDUSTRY N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles H. Gross | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Charlotte Parker | | | |
| 19a. INFORMANT'S NAME (Type/Print) Charlotte Parker | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3453 Holmead Place, NW Washington, DC 20010 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Suburban Crematory | | 20c. LOCATION — City or Town, State Silver Spring, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY W.H. Bacon Funeral Home 3447 14th Street, N.W. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hypertension DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Disseminated intravascular coagulation DUE TO (OR AS A CONSEQUENCE OF): sepsis DUE TO (OR AS A CONSEQUENCE OF): Gangrene of scrotum and lower penis | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Possible Human Immunodeficiency Syndrome | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER D18055 | | 29d. DATE SIGNED (Month, Day, Year) 4/23/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ronald L. Gandy, MD 9440 Pines/Valley Ave, Upper Merion/Penn | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 24 90 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be signed by the hospital or attending physician, and the funeral director must be notified by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

19081 02

90 13042

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LAURA V. PERDUE | | | | 2. DATE OF DEATH MONTH 4 DAY 21 YEAR 90 | | 3. TIME OF DEATH 0410 A M | |
| 4. SOCIAL SECURITY NUMBER 220-26-2995 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 97 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05-31-1892 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) Hartley Hall Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH Pocomoke City | |
| 9c. COUNTY OF DEATH Worcester | | | | 10a. STATE MARYLAND | | 10b. COUNTY WORCESTER | |
| 10c. CITY, TOWN OR LOCATION POCOMOKE CITY | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1210 MARKET STREET | |
| 10f. ZIP CODE 21851 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 YEARS College (1-4 or 5+) NO | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSE WIFE | | 16b. KIND OF BUSINESS/INDUSTRY HOME | |
| 17. FATHER'S NAME (First, Middle, Last) ALEX -- JOHNSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) GEORGIANNA -- SCARBOROUGH | | | |
| 19a. INFORMANT'S NAME (Type/Print) RUTH P McKAY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 147, POCOMOKE CITY, MD 21851 | | | |
| 20a. METHOD OF DISPOSITION 4/23/90 <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BETHEL CEMETERY | | 20c. LOCATION — City or Town, State WALSTON SWITCH, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY HOLLOWAY FUNERAL HOME, PA 501 SNOW HILL RD, SALISBURY, MD 21801 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASPIRATION PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DS | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D34576 | | 29d. DATE SIGNED (Month, Day, Year) 4/23/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RONALD P. TRAVITZ MD 560 RIVERSIDE DR. SALISBURY 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 26 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) SHERMAN H. PUTNAM | | | | 2. DATE OF DEATH MONTH 4 DAY 27 YEAR 1990 | | 3. TIME OF DEATH 1:05PM M | |
| 4. SOCIAL SECURITY NUMBER 217-40-7026 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 45 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7/2/1944 | |
| 8. BIRTHPLACE (State or Foreign Country) Tennessee | | | | 9. COUNTY OF DEATH Harford | | | |
| 10. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital | | | | 11. CITY, TOWN OR LOCATION OF DEATH Havre de Grace | | 12. COUNTY OF DEATH Harford | |
| 13. STATE Maryland | | 14. COUNTY Harford | | 15. CITY, TOWN OR LOCATION Bel Air | | 16. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 17. STREET AND NUMBER 100 Idlewild Street | | | | 18. ZIP CODE 21014 | | 19. CITIZEN OF WHAT COUNTRY? USA | |
| 20. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 21. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 23. RACE — American Indian, Black, White, etc. Specify: White | |
| 24. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+) 0 | | 25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction Worker | | 26. KIND OF BUSINESS/INDUSTRY Construction | | | |
| 27. FATHER'S NAME (First, Middle, Last) Mallie K. Putnam | | | | 28. MOTHER'S NAME (First, Middle, Maiden Surname) Euna Aldridge | | | |
| 29. INFORMANT'S NAME (Type/Print) David Putnam | | | | 30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Fairwood Road Apt K Bel Air, MD 21014 | | | |
| 31. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 32. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Memorial Gardens | | 33. LOCATION — City or Town, State Middle River, MD | | | |
| 34. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert M. [Signature]</i> | | | | 35. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P. A. Aberdeen, Maryland 21001-3399 | | | |
| 36. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | 37. Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| 38. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 39. 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 40. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 41. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 42. 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 43. 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 44. 28a. DATE OF INJURY (Month, Day, Year) 4-26-90 | | 45. 28b. TIME OF INJURY 9:40 AM | | 46. 28c. INJURY AT WORK? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 47. 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Bridge | | 48. 28e. DESCRIBE HOW INJURY OCCURRED Operator of crane that over- | | | |
| | | | | 49. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) turned Hattem Toll Bridge, Rt. 40, Harford Co., MD | | | |
| 49. 29a. CERTIFIER 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 50. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 51. 29c. LICENSE NUMBER OCME | | 52. 29d. DATE SIGNED (Month, Day, Year) 4-28-90 | |
| 53. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James A. Kaplan, M.D. 111 Penn St., Balto., MD 21201 | | | | | | | |
| 54. 31. DATE FILLED (Month, Day, Year) MAY 01 90 | | | | 55. 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

90 13044

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Mary A Queen</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>4 28 1990</i> | | 3. TIME OF DEATH <i>5:40 A M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>218-30-4100</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) <i>96</i> YRS. | 7. DATE OF BIRTH (Month, Day, Year) <i>2-2-94</i> | 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Holy Cross Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i> | | 9c. COUNTY OF DEATH <i>Montgomery</i> | |
| 10a. STATE <i>Maryland</i> | | | | 10b. COUNTY <i>Prince Georges</i> | | 10c. CITY, TOWN OR LOCATION <i>Beltsville</i> | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER <i>13225 Greenmount Avenue</i> | | | | 10f. ZIP CODE <i>20705</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>American Ind.</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 6</i> | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Powder Line Worker</i> | | 16. KIND OF BUSINESS/INDUSTRY <i>US Government</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>John W. Swann</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>unavailable</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Charles M. Queen</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>13225 Greenmount Ave., Beltsville, Md. 20705</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Charles Cemetery</i> | | 20c. LOCATION — City or Town, State <i>Glymont, Md.</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Will Black</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Hunt Funeral Home P. O. Box 156, Waldorf, Md. 20604-0156</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death <i>3 days</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE NOW INJURY OCCURRED | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Will Black MD</i> | | | | 29c. LICENSE NUMBER <i>D01120</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>28 APRIL 1990</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>2309 SHOREFIELD ROAD WHEATON, MD 20902</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 01 '90</i> | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or date, appearing as "1912" or similar.

90 13045

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DEBORAH QUIGLEY | | | | 2. DATE OF DEATH MONTH DAY YEAR 04 19 90 | | 3. TIME OF DEATH 1:27 A M | |
| 4. SOCIAL SECURITY NUMBER 577-86-1288 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 29 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 23, 1960 | |
| 9a. FACILITY NAME (If not Institution, give street and number) PRINCE GEORGE'S HOSPITAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY | | 9c. COUNTY OF DEATH PRINCE GEORGE'S | |
| 10a. STATE Maryland | | | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Seat Pleasant | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 501 62nd Ave. | | | |
| 10f. ZIP CODE 20743 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) 1-2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unemployed | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Aaron Lawson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia Greene | | | |
| 19a. INFORMANT'S NAME (Type/Print) Betty Gunby | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3905 Park Blvd. Suitland, MD 20746 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park | | 20c. LOCATION — City or Town, State Landover, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Henry D. Delahanty</i> | | | | 22. NAME AND ADDRESS OF FACILITY Robert G. Mason Funeral Home 1661 Good Hope Rd., SE Wash., DC 20020 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. POORLY DIFFERENTIATED MALIGNANT NEOPLASM DUE TO (OR AS A CONSEQUENCE OF): b. PROBABLE MALIGNANT LYMPHOMA DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Davidson-Randall</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 4/22/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1140 VARNUM ST. NE. WASHINGTON, D.C. 20017 (202) 526-9156 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 26 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 of this certificate is to be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified once.

20 13042

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DMMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEASED'S NAME (First, Middle, Last) Ruth C. Reio | | | | 2. DATE OF DEATH MONTH DAY YEAR 04-24-90 | | 3. TIME OF DEATH 0650 M | |
| 4. SOCIAL SECURITY NUMBER 218-14-5995 | | 5. SEX <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 09-17-09 | |
| 8a. FACILITY NAME (If not institution, give street and number) North Arundel General Hospital | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie | | 8c. COUNTY OF DEATH Anne Arundel | |
| 10a. STATE MD | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Millersville | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1117 Dicus Mill Road | | | | 10f. ZIP CODE 21108 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Household | | | |
| 17. FATHER'S NAME (First, Middle, Last) Franklin M. Jeffers | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice J. Colquitt | | | |
| 19a. INFORMANT'S NAME (Type/Print) George R. Reio | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1117 Dicus Mill Road, Millersville, MD | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Louden Park Cemetery | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia J. Smith</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home P.A. 851 Annapolis Road, Gambrills, MD | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): ASCVD Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>William P. Jones, MD Deputy</i> | | | | 29c. LICENSE NUMBER D06054 | | 29d. DATE SIGNED (Month, Day, Year) 4/24/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William P. Jones, MD 695 America 21035 | | | | | | | |
| 31. DATE SIGNED (Month, Day, Year) APR 26 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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20 13011

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Thomas Michael RANDALL | | | | 2. DATE OF DEATH MONTH DAY YEAR April 14, 1990 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 220-28-8907 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 23, 1932 | |
| 8a. FACILITY NAME (If not institution, give street and number) 18532 Lappans Road | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Boonsboro | | 8c. COUNTY OF DEATH Washington | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Washington | | 10c. CITY, TOWN OR LOCATION Boonsboro | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 18532 Lappans Road | | | | 10f. ZIP CODE 21713 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-11 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) street dept. | | 15b. KING OF BUSINESS/INDUSTRY City of Hagerstown | | | |
| 17. FATHER'S NAME (First, Middle, Last) Roger Randall | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Knight | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Vickie Carter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 West Potomac Street, Williamsport, MD 21795 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park | | 20c. LOCATION — City or Town, State Hagerstown, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott M. Minnich</i> | | 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, MD 21740 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ADENOCARCINOMA OF RIGHT LUNG</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>CHRONIC SMOKING</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CAERHIXIA. EMPHYSEMA</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>James P. Harrison</i> | | | | 29c. LICENSE NUMBER D17067 | | 29d. DATE SIGNED (Month, Day, Year) 4/16/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print) STEPHEN METZGER, MD 825 Hawken Rd Hagerstown, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 17 '90 | | 32. REGISTRAR'S SIGNATURE <i>Juha Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30 13048

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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Roger Fairfax Rowley, Jr. | | | | 2. DATE OF DEATH MONTH 04 DAY 13 YEAR 90 | | 3. TIME OF DEATH 10:00 A M | |
| 4. SOCIAL SECURITY NUMBER 579-44-3362 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 54 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10/10/35 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington, DC | | | | 9a. FACILITY NAME (If not institution, give street and number) 9214 Mintwood Street | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 9214 Mintwood Street | |
| 10f. ZIP CODE 20901 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Business Rep. | | | | 16b. KIND OF BUSINESS/INDUSTRY Glazer Local Union 963 | | | |
| 17. FATHER'S NAME (First, Middle, Last) Roger Fairfax Rowley, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lydia Gertrude Haines | | | |
| 19a. INFORMANT'S NAME (Type/Print) Barbara J. Rowley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9214 Mintwood Street, Silver Spring, Maryland | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery | | 20c. LOCATION — City or Town, State Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Frank A. Bolson</i> | | | | 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Cigarette Smoking c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ernest Oser MD</i> | | | | 29c. LICENSE NUMBER D03792 | | 29d. DATE SIGNED (Month, Day, Year) 4/13/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ernest Oser, 10301 Georgia Avenue, Silver Spring, Maryland 20902 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 23 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

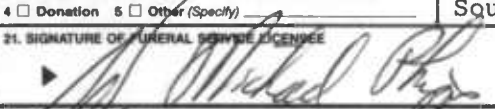
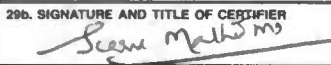

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 13069

90 13050

1 - FOR
STATE
REGISTRAR MOLLIE E. REYNOLDS
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MOLLIE E. REYNOLDS | | | | 2. DATE OF DEATH MONTH 4 DAY 28 YEAR 90 | | 3. TIME OF DEATH 11:30 A.M. | |
| 4. SOCIAL SECURITY NUMBER 239 10 2025 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8-25-07 | |
| 9a. FACILITY NAME (If not institution, give street and number) Calvert County Nursing Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Prince Frederick | | 9c. COUNTY OF DEATH Calvert | |
| 10a. STATE MD | | | | 10b. COUNTY Charles | | 10c. CITY, TOWN OR LOCATION LaPlata | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 301 Linden Lane | | | |
| 10f. ZIP CODE 20646 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | 16b. KIND OF BUSINESS/INDUSTRY Educational Institution | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Hardy | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) unk | | | |
| 19a. INFORMANT'S NAME (Type/Print) Karen R. Hooper | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Southern Memorial Gardens | | 20c. LOCATION — City or Town, State Dunkirk (Calvert) MD | | | |
| 21. SIGNATURE OF FURNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, Owings, MD 20736 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ALZHEIMERS DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death 10 years | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  PHYSICIAN | | | | 29c. LICENSE NUMBER D 36969 | | 29d. DATE SIGNED (Month, Day, Year) 4/28/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SCARIA MATHEW MD 11800 H.C. TRUEMAN RD LUSBY MD 20657. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 01 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It is to be signed by the attending physician and completely filled in by the funeral director. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

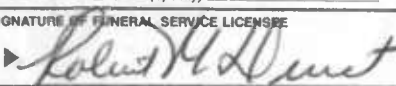


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

50 13020

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BURTON EDWARD RHODES | | | | 2. DATE OF DEATH MONTH DAY YEAR April 8, 1990 | | 3. TIME OF DEATH 10:00 P.M. | |
| 4. SOCIAL SECURITY NUMBER 218-01-7212 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 7, 1906 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Oakland | |
| 9c. COUNTY OF DEATH Garrett | | | | 10a. STATE Maryland | | 10b. COUNTY Garrett | |
| 10c. CITY, TOWN OR LOCATION Deer Park | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER Rt. 3 Box 3045 | |
| 10f. ZIP CODE 21550 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) Trackman | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Trackman | | | | 16b. KIND OF BUSINESS/INDUSTRY Railroad | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edgar Rhodes | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret "Rhodes" | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Betty Sebold | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 4 Box 46 Deer Park, Md. 21550 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Deer Park Cemetery | | | |
| 20c. LOCATION — City or Town, State Deer Park, Maryland | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00167 | | | |
| 22. NAME AND ADDRESS OF FACILITY P.O. Box 243 Durst Funeral Home - Oakland, Md. 21550 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Acute cholecystitis b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval between Onset and Death 2 weeks 3 weeks | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Terminal Dementia of Alzheimer's type Urinary Tract Infection | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER  MD | | | |
| 29c. LICENSE NUMBER D27205 | | | | 29d. DATE SIGNED (Month, Day, Year) 4/9/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Karl E. Schwalm 411 N. 4th Street Oakland, Md. 21550 | | | | 31. DATE FILED (Month, Day, Year) APR 10 '90 | | | |
| 32. REGISTRAR'S SIGNATURE  | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 9 of the certificate must be filed with the funeral director. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

Karl

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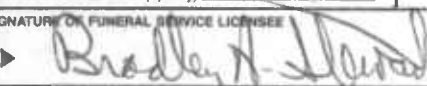
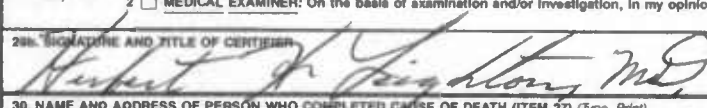



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90 13052

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Woodrow Ross REXRODE | | | | 2. DATE OF DEATH MONTH DAY YEAR April 05 1990 | | 3. TIME OF DEATH 6:29 p.m. | |
| 4. SOCIAL SECURITY NUMBER 217-03-6075 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 6, 1915 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Oakland | |
| 9c. COUNTY OF DEATH Garrett | | | | 10a. STATE MD | | 10b. COUNTY Garrett | |
| 10c. CITY, TOWN OR LOCATION Oakland | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER Rt. 1, Box 4 | |
| 10f. ZIP CODE 21550 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Heavy Equipment Oper. | | 16b. KIND OF BUSINESS/INDUSTRY Mining/Construction | |
| 17. FATHER'S NAME (First, Middle, Last) Harry ----- Hardesty | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Amanda Katherine Rexrode | | | |
| 19a. INFORMANT'S NAME (Type/Print) Darrell L. Rexrode | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 95 Powles Ave., Mt. Lake Park, MD 21550 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) King Cemetery | | 20c. LOCATION — City or Town, State Deer Park, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardio-Vascular Disease | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D 05658 | | 29d. DATE SIGNED (Month, Day, Year) April 6, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Herbert H. Leighton, M.D., Oak @ 5th Sts., Oakland, Maryland 21550 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 9 '90 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 46

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DO 13025

90 13053

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Lois Manila Rollman | | | | 2. DATE OF DEATH MONTH DAY YEAR April 06 1990 | | 3. TIME OF DEATH p m 8:00 p m | |
| 4. SOCIAL SECURITY NUMBER 579-16-3597 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) YRS. 67 | | 7. DATE OF BIRTH (Month, Day, Year) 7/19/1923 | |
| 9a. FACILITY NAME (If not institution, give street and number) Garrett Co. Memorial Hosp. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Oakland, | | 9c. COUNTY OF DEATH Garrett | |
| 10a. STATE Md. | | | | 10b. COUNTY Garrett | | 10c. CITY, TOWN OR LOCATION Mt. Lake | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER Holly Lane | | | | 10f. ZIP CODE 21550 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) -0- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Claude Friend | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Manila Bay Uphold | | | |
| 19a. INFORMANT'S NAME (Type/Print) James rollman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holly Lane Mt. Lake Park, Md. 21550 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Deer Park Cemetery | | 20c. LOCATION — City or Town, State Deer Park, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE David A. Burdock | | | | 22. NAME AND ADDRESS OF FACILITY Burdock F. H. Kitzmiller, Md. 21538 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | minutes |
| a. Ventricular Fibrillation | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Ischemic Heart Disease | | | | | | | Sev. yrs. |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Arteriosclerotic Cardio-Vascular Disease | | | | | | | Unknown |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rheumatoid Arthritis, severe 30 years Diabetes mellitus | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> VER/Outpatient 3 <input type="checkbox"/> DOA | | OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 26. PLACE OF DEATH (Check only one) | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Herbert H. Leighton M.D. | | | | 29c. LICENSE NUMBER D 05658 | | 29d. DATE SIGNED (Month, Day, Year) April 6, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Herbert H. Leighton, M.D., Oak @ 5th Sts., Oakland, Maryland 21550 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 9 '90 | | 32. REGISTRAR'S SIGNATURE John L. ... | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 13054

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Louise C. Ridgely</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>04-29-1990</i> | | 3. TIME OF DEATH <i>0252</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>219-36-1730</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>87</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>06-21-1902</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Austria</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>Carroll County General Hospital Westminster</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Carroll</i> | |
| 10a. STATE <i>Md</i> | | | | 10b. COUNTY <i>Carroll</i> | | 10c. CITY, TOWN OR LOCATION <i>Sykesville</i> | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER <i>5525 Sykesville Road</i> | | 10f. ZIP CODE <i>21784</i> | |
| 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i> | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housekeeping</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY <i>Springfield Hospital Center</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Jacob Peljac</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Unknown</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Adam Marion Cook</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5525 Sykesville Road Sykesville, MD 21784</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Springfield Cemetery</i> | | 20c. LOCATION — City or Town, State <i>Sykesville, MD</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Brian L. Haight</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Haight Funeral Home (P.O. Box 195) Sykesville, MD 21784 (301)-795-1400</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Severe Congestive heart failure</i> | | | | | | | <i>3 days</i> |
| DUE TO (OR AS A CONSEQUENCE OF): <i>acute myocardial infarction</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus, Chronic renal failure</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>D. S. Kalaria</i> | | | | 29c. LICENSE NUMBER <i>D23015</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>4/29/90</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>D. S. KALARIA, 217 Washington Hts. Westminster Md 21157</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 1 '90</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Bruce Cooper Davis Russell</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>4 26 90</i> | | 3. TIME OF DEATH <i>7:30 PM</i> | |
| 4. SOCIAL SECURITY NUMBER <i>186-01-1247</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>71</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>8 12 18</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Virginia</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>1101 Oakdale</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Joppa</i> | |
| 9c. COUNTY OF DEATH <i>Harford</i> | | | | 10a. STATE <i>Maryland</i> | | 10b. CITY, TOWN OR LOCATION <i>Joppa</i> | |
| 10c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10d. STREET AND NUMBER <i>1102 Oak Avenue</i> | | 10e. ZIP CODE <i>Joppa</i> | |
| 10f. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WWII</i> | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <i>12</i> College (1-4 or 5+) <i>College</i> | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Welder</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY <i>Construction</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Richard (nmn) Russell</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Edna Florence Wetzel</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Madalynn Johnson</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Lancaster, Pa.</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Conestoga Memorial Park</i> | | 20c. LOCATION (City or Town, State) <i>Lancaster, Pa.</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. McComas III</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>anticoagulation Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard J. Colfer, MD</i> | | | | 29c. LICENSE NUMBER <i>DO 1194</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>4/26/90</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>RICHARD J. COLFER, MD 2013 Trenchard Church Rd Abingdon, MD</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>APR 30 '90</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Gina Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Fred Franklin Racey Sr. | | | | 2. DATE OF DEATH MONTH DAY YEAR April 27 1990 | | 3. TIME OF DEATH 04:30A: M | |
| 4. SOCIAL SECURITY NUMBER 215-18-0240 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 08-03-1916 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH LaPlata | |
| 9c. COUNTY OF DEATH Charles | | | | 10a. STATE Maryland | | 10b. COUNTY Charles | |
| 10c. CITY, TOWN OR LOCATION La Plata | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER Route 225 Box 1042 | |
| 10f. ZIP CODE 20646 | | | | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician | | | | 16b. KING OF BUSINESS/INDUSTRY So. Maryland Oil | | | |
| 17. FATHER'S NAME (First, Middle, Last) Arthur F. Racey | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna A. Ginn | | | |
| 19a. INFORMANT'S NAME (Type/Print) June M. Racey | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1042 La Plata, Maryland 20646 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Ignatius Cemetery | | | |
| 20c. LOCATION — City or Town, State Hill Top, Maryland | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE David C. Eckels | | | |
| 22. NAME AND ADDRESS OF FACILITY Arehart Funeral Home, Inc. La Plata, Maryland 20646-0567 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Sepsis c. Leukemia d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery disease Metastatic Prostate Cancer | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 4/27/90 | | | |
| 28b. TIME OF INJURY M 4:30 | | | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Benjamin L. Jenkins M.D. | | | | 29c. LICENSE NUMBER D33426 | | | |
| 29d. DATE SIGNED (Month, Day, Year) 4/27/90 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Benjamin L. Jenkins M.D. P.O. Box 1724 LaPlata Md, 20646 | | | |
| 31. DATE FILED (Month, Day, Year) APR 30 '90 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13057

| | | | | | | | |
|---|--|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN E. Revel | | | | 2. DATE OF DEATH MONTH DAY YEAR April 19 1990 | | 3. TIME OF DEATH 1740 M | |
| 4. SOCIAL SECURITY NUMBER 222-22-0743 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 8. AGE (In yrs. last birthday) 55 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 5/13/34 | |
| 9a. FACILITY NAME (If not institution, give street and number) Peninsula General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Salisbury, MD | | 9c. COUNTY OF DEATH Wicomico | |
| 10a. STATE Delaware | | | | 10b. COUNTY Sussex | | 10c. CITY, TOWN OR LOCATION Millsboro | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER rt. 3 Box 207 | | | | 10f. ZIP CODE 19966 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) clerk | | 16b. KIND OF BUSINESS/INDUSTRY office worker | | | |
| 17. FATHER'S NAME (First, Middle, Last) Willie Revel | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Collins | | | |
| 19a. INFORMANT'S NAME (Type/Print) LAURA REVEL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 3 Box 207, Millsboro, Delaware 19966 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Bethel Cemetery | | 20c. LOCATION — City or Town, State Willards, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard T. Watson | | | | 22. NAME AND ADDRESS OF FACILITY Watson Funeral Home, Inc. Millsboro, Delaware 19966 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hepatic Failure Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Angiosarcoma of The Liver b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) N/A | |
| | | 28b. TIME OF INJURY N/A M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED N/A | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Joseph L. Raffetto | | | | 29c. LICENSE NUMBER D20441 | | 29d. DATE SIGNED (Month, Day, Year) 4-20-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph L. RAFFETTO Quincey and Locust St. Salisbury, Md. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 24 '90 | | 32. REGISTRAR'S SIGNATURE John E. Revel | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

90 13027

90 13058

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY Dillard Robinson | | | | 2. DATE OF DEATH MONTH 4 - DAY 17 - YEAR 1990 | | 3. TIME OF DEATH 6:45P | |
| 4. SOCIAL SECURITY NUMBER 577-18-8601 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-31-06 | |
| 8. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital | | | | 9a. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE D.C. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION WASHINGTON | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 43 ADAMS St. N.W. | | | | 10f. ZIP CODE 20001 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 16+) <input checked="" type="checkbox"/> 2 yrs. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RETIRED GOVT | | 16b. KIND OF BUSINESS/INDUSTRY U.S. GOVT | | | |
| 17. FATHER'S NAME (First, Middle, Last) ROBERT DILLARD | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EMMA CEPHAS | | | |
| 19a. INFORMANT'S NAME (Type/Print) FRANCES EDWARDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10.E. | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) LINCOLN CEMETERY | | 20c. LOCATION — City or Town, State SUITLAND, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.J. Syfers | | | | 22. NAME AND ADDRESS OF FACILITY 399 RHODE ISLAND AVE. WASH. DC. 20001 FRAZIER'S FUNERAL HOME | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis DUE TO (OR AS A CONSEQUENCE OF): a. Ascending Cholangitis b. Cholelithiasis c. Obstructive Jaundice d. Obstructive Jaundice Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration, Renal failure | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Brayendra Nath Misra ATTENDING SURGEON | | | | 29c. LICENSE NUMBER 220069 | | 29d. DATE SIGNED (Month, Day, Year) 04.17.90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. BRAYENDRA N MISRA SUITE B 7207 HANOVER PKWY GREENBELT MD 20770 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 24 '90 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 of this certificate is to be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

00 13023



90 13059

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) John Avon Roberts | | | | 2. DATE OF DEATH MONTH DAY YEAR 04 18 1990 | | 3. TIME OF DEATH 12:00P M | |
| 4. SOCIAL SECURITY NUMBER 577-01-2081 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 92YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-01-1897 | |
| 8. BIRTHPLACE (State or Foreign Country) West Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) Hartley Hall Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH Pocomoke City | |
| 9c. COUNTY OF DEATH Worcester | | | | 10a. STATE Maryland | | 10b. COUNTY Somerset | |
| 10c. CITY, TOWN OR LOCATION PRINCESS ANNE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER RT 2, BOX 122 | |
| 10f. ZIP CODE 21853 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) UNK | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) EMPLOYEE | | | | 16b. KIND OF BUSINESS/INDUSTRY TELEPHONE COMPANY | | | |
| 17. FATHER'S NAME (First, Middle, Last) JEFFERSON --- ROBERTS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA MAE KINCAID | | | |
| 19a. INFORMANT'S NAME (Type/Print) JOHN R. ROBERTS, SR. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RT 2, BOX 122, PRINCESS ANNE, MD 21853 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) PLEASANT HILL CEMETERY | | | |
| 20c. LOCATION — City or Town, State SMITH CREEK, WEST VIR. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Holloway</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY HOLLOWAY FUNERAL HOME, PA 501 SNOW HILL RD, SALISBURY, MD 21801 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. ASCVD DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Allen, M.D.</i> | | | | 29c. LICENSE NUMBER D29168 | | 29d. DATE SIGNED (Month, Day, Year) 4/19/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT ALLEN 305 10TH ST., POCOMOKE, MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 26 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 19025

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Patrick Stanford | | | | 2. DATE OF DEATH MONTH 4 DAY 15 YEAR 90 | | 3. TIME OF DEATH 2:49 A. M | |
| 4. SOCIAL SECURITY NUMBER 577-08-5539 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 25 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 4, 1967 | |
| 9a. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Clinton | | 9c. COUNTY OF DEATH Prince George's | |
| 10a. STATE DC | | | | 10b. COUNTY Washington | | 10c. CITY, TOWN OR LOCATION Washington | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3401 1/2 13th Street, S. E. # 105 | | 10f. ZIP CODE 20032 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chief Security | | | | 16b. KIND OF BUSINESS/INDUSTRY Pan Am Airlines | | 17. FATHER'S NAME (First, Middle, Last) Junius H. Maples | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Irmgard E. | | | | 19a. INFORMANT'S NAME (Type/Print) Junius H. Maples | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Kennedy St., NW #4 Washington, DC 20011 | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lee's Crematory | | 20c. LOCATION — City or Town, State Washington, DC | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE J. P. Marshall | | | | 22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home 4217 9th Street, N. W. Washington, D. C. 20011 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Stab Wounds DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Homicide | |
| 28a. DATE OF INJURY (Month, Day, Year) 4-15-90 | | | | 28b. TIME OF INJURY 2:07A M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED subject was stabbed | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) street | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Allentown Rd. & Branch Ave., Camp Springs, Md. | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Ann M. Dixon, M.D. | | 29c. LICENSE NUMBER OCME | |
| 29d. DATE SIGNED (Month, Day, Year) 4-15-90 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann M. Dixon, M.D. 111 Penn St., Balto., Md. 21201 | | 31. DATE FILED (Month, Day, Year) APR 18 '90 | |
| 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Jim Spencer</u> | | | | 2. DATE OF DEATH MONTH <u>April</u> DAY <u>11</u> YEAR <u>1990</u> | | | | 3. TIME OF DEATH <u>10:30 PM</u> | | | | | |
| 4. SOCIAL SECURITY NUMBER <u>420-16-0442</u> | | | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>94</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>3-4-1896</u> | | 8. BIRTHPLACE (State or Foreign Country) <u>Sawverville, Ala</u> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Leeland Mem. Hosp. Riverdale</u> | | | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Prince Georges</u> | | 9c. COUNTY OF DEATH <u>Prince Georges</u> | | | |
| 10a. STATE <u>Md</u> | | | | 10b. COUNTY <u>PG</u> | | | | 10c. CITY, TOWN OR LOCATION <u>College Park</u> | | | | | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER <u>4817 Erie Street</u> | | | | 10f. ZIP CODE <u>20740</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u> | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>4th</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Foundryman</u> | | | | | |
| 16b. KIND OF BUSINESS/INDUSTRY <u>Central Foundry</u> | | | | 17. FATHER'S NAME (First, Middle, Last) <u>Joe Spencer</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Martha Hawkins</u> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Thaddeus Steel</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4817 Erie Street St., College Park, Md. 20740</u> | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Druid Funeral Service</u> | | | | 20c. LOCATION — City or Town, State <u>Tuscolusso, Ala.</u> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>J. P. Marshall</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Marshall's Funeral Home</u> <u>4217 9th Street NW: Washington, D.C.</u> | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Acute Myocardial Disease</u> a. <u>Acute Myocardial Dis.</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>None</u> | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u> | | | | | | | | 29c. LICENSE NUMBER <u>109975</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>April 11, 1990</u> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>APR 16 '90</u> | | | | 32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-11-00

90 13062

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Betty J. Beltz Stevens | | | | 2. DATE OF DEATH MONTH DAY YEAR APRIL 15 1990 | | 3. TIME OF DEATH 2:30 P.M. | |
| 4. SOCIAL SECURITY NUMBER 217-42-3665 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 59 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05 21 30 | |
| 8. BIRTHPLACE (State or Foreign Country) Newport News, VA | | | | 9a. FACILITY NAME (If not institution, give street and number) Southern Md. Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Clinton | |
| 9c. COUNTY OF DEATH P.G. | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George's | |
| 10c. CITY, TOWN OR LOCATION Clinton | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 9008 Spring Acres Road | |
| 10f. ZIP CODE 20735 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Home | |
| 17. FATHER'S NAME (First, Middle, Last) George Marquis Beltz | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Thelma J. Goodman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Edward A. Stevens | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10 A-F | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lee Crematory | | 20c. LOCATION — City or Town, State Clinton, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd Clinton, Md 20735 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. SEVERE ASTHMATIC BRONCHITIS DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. Approximate interval between Onset and Death 10 MIN 3 YRS. 6 YRS. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Arthur Shaver MD | | | |
| 29c. LICENSE NUMBER A10095 (MD) | | | | 29d. DATE SIGNED (Month, Day, Year) 4/15/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ARTHUR SHAVER JR MD - 9131 PISCATAWAY RD CLINTON MD 20735 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 19 '90 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Quentin SHAW | | | | 2. DATE OF DEATH MONTH 4 DAY 13 YEAR 90 | | 3. TIME OF DEATH 8-07A | |
| 4. SOCIAL SECURITY NUMBER 082-07-8395 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-13-09 | |
| 8. BIRTHPLACE (State or Foreign Country) N.J. | | | | 9a. FACILITY NAME (If not institution, give street and number) SOUTHERN Maryland Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH CLINTON | |
| 9c. COUNTY OF DEATH PRINCE GEORGES | | | | 10a. STATE Md. | | 10b. COUNTY P.G. | |
| 10c. CITY, TOWN OR LOCATION Oxon Hill | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 407 Barrymore Drive | |
| 10f. ZIP CODE 20745 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Communications | | | | 16b. KIND OF BUSINESS/INDUSTRY Federal Gov't | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Shaw | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Christina King | | | |
| 19a. INFORMANT'S NAME (Type/Print) Gloria Shaw | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10a-10f. | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lee Crematory | | | |
| 20c. LOCATION — City or Town, State Clinton, Md. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | |
| 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Maryland 20735 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute myocardial infarction Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST ASCVD PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. polycythemia vera, Acute CVA | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) NA | | | |
| 28b. TIME OF INJURY M | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Frank M. Ryan M.D. | | | | 29c. LICENSE NUMBER D19431 | | | |
| 29d. DATE SIGNED (Month, Day, Year) 4/13/90 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2401 Indian Head Highway, Ft. Washington, Md 20744 | | | |
| 31. DATE FILED (Month, Day, Year) APR 19 '90 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13064

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) CAROLYN Anne SHEA | | | | 2. DATE OF DEATH MONTH DAY YEAR 04 18 90 | | 3. TIME OF DEATH 9 20AM M | |
| 4. SOCIAL SECURITY NUMBER 214-42-2808 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 46 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03 07 44 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not Institution, give street and number) PRINCE GEORGES HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY | |
| 9c. COUNTY OF DEATH PRINCE GEORGES | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George's | |
| 10c. CITY, TOWN OR LOCATION Hyattsville | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 3422 Purdue Street | |
| 10f. ZIP CODE 20783 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12th College (1-4 or 5+) 2nd | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Broker | | 16b. KIND OF BUSINESS/INDUSTRY Real Estate | |
| 17. FATHER'S NAME (First, Middle, Last) Walter Anthony Shea | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia E. McNamara | | | |
| 19a. INFORMANT'S NAME (Type/Print) Kevin Shea | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3422 Purdue Street, Hyattsville, Maryland 20783 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery | | 20c. LOCATION — City or Town, State Brentwood, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Paul J. Borman</i> | | | | 22. NAME AND ADDRESS OF FACILITY FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Balt., Ave., Hyattsville, Md. 20781 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiorespiratory arrest</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <i>Endocarditis</i> b. DUE TO (OR AS A CONSEQUENCE OF): <i>End-stage Renal Disease</i> c. DUE TO (OR AS A CONSEQUENCE OF): <i>Arterial nephropathy</i> | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D19891 | | 29d. DATE SIGNED (Month, Day, Year) 4/18/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Abraham B. DABELA 4404 Queensbury Rd. Bethesda, MD 20814 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 23 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Josephine Evelyn SHERWOOD | | | | 2. DATE OF DEATH MONTH DAY YEAR April 17, 1990 | | 3. TIME OF DEATH 6:14 a.m. ^M | |
| 4. SOCIAL SECURITY NUMBER 578-12-7317 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MARCH 27, 1921 | |
| 8. BIRTHPLACE (State or Foreign Country) MITCHEVILLE MD. | | | | 9a. FACILITY NAME (If not institution, give street and number) AMI DOCTORS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH LANHAM | |
| 9c. COUNTY OF DEATH Prince Georges | | | | 10a. STATE Maryland | | 10b. COUNTY Prince Georges | |
| 10c. CITY, TOWN OR LOCATION Lanham | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 9510 Worrell Ave. | |
| 10f. ZIP CODE 20706 | | | | 10g. CITIZEN OF WHAT COUNTRY? US | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bookkeeper | | 16b. KIND OF BUSINESS/INDUSTRY Citizens Bank of MD. | |
| 17. FATHER'S NAME (First, Middle, Last) Frank Hart | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Amelia Bateman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Harold Sherwood | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9510 Worrell Ave. Lanham, Maryland 20706 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln | | 20c. LOCATION — City or Town, State Brentwood, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Declan Hester</i> | | | | 22. NAME AND ADDRESS OF FACILITY Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>cardiac arrest</i> Sequently conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>cardiovascular failure</i> b. <i>multiple myeloma</i> c. <i>multiple myeloma</i> d. <i>multiple myeloma</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>arteriosclerosis</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John William Dunno Jr. MD</i> | | | | 29c. LICENSE NUMBER D01499 | | 29d. DATE SIGNED (Month, Day, Year) 4/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 20 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20 13062

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Gregory F. Smirnoff | | | | 2. DATE OF DEATH MONTH DAY YEAR 4 / 15 / 90 | | 3. TIME OF DEATH 8:00 a.m. | | | |
| 4. SOCIAL SECURITY NUMBER 229-44-9314 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 4, 1918 | | | |
| 8. BIRTHPLACE (State or Foreign Country) Japan | | | | 9. FACILITY NAME (If not institution, give street and number) Southern Md. Hospital | | 10. CITY, TOWN OR LOCATION OF DEATH Clinton | | | |
| 11. COUNTY OF DEATH P.G. | | | | 12. RESIDENCE OF DECEASED 10a. STATE Maryland 10b. COUNTY Prince George's 10c. CITY, TOWN OR LOCATION Fort Washington 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 13305 Chalfont Avenue 10f. ZIP CODE 20744 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self Employed | | 16b. KIND OF BUSINESS/INDUSTRY Sales | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Feodor Smirnoff | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown Unknown | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Olga H. Smirnoff | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13305 Chalfont Ave. Ft. Washington, Md. 20744 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery | | 20c. LOCATION — City or Town, State Brentwood, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE George P. Kalas | | | | 22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Maryland | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): Recurrent Arrhythmia DUE TO (OR AS A CONSEQUENCE OF): CVA, severe Approximate interval between Onset and Death 51 hr | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Previous CVA, Hypertension, Renal failure, Abdominal Aortic Aneurysm | | | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Michael D. Levine | | 29c. LICENSE NUMBER D24945 | | 29d. DATE SIGNED (Month, Day, Year) APRIL 15, 1990 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael D. Levine, M.D. 1701 Old Branch Ave #409 Clinton, MD. 20735 | | | | | | 31. DATE FILED (Month, Day, Year) APR 20 '90 | | 32. REGISTRAR'S SIGNATURE Julian Davidson-Randall | |

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

4-20090

6:45pm

90 13067

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William Sampson | | | | 2. DATE OF DEATH MONTH 4 DAY 20 YEAR 90 | | 3. TIME OF DEATH 6:45P | |
| 4. SOCIAL SECURITY NUMBER 219-01-6757 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month/Day/Year) 11/2/19 | |
| 9a. FACILITY NAME (If not institution, give street and number) DGH | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CAMBRIDGE Md | | 9c. COUNTY OF DEATH DORCHESTER | |
| 10a. STATE MD | | | | 10b. COUNTY DORCHESTER | | 10c. CITY, TOWN OR LOCATION EAST NEW MKT | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER Rt 1 Box 9-A | | | |
| 10f. ZIP CODE 21631 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 7th College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Janitor | | 16b. KIND OF BUSINESS/INDUSTRY Elementary School | | | |
| 17. FATHER'S NAME (First, Middle, Last) Ernest Sampson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Beatrice Dockins Sampson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lena R. Sampson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3742 Silver Park Court, Suitland, MD 20746 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) East New Market Cem. | | 20c. LOCATION — City or Town, State East New Market, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael J. Eskow | | | | 22. NAME AND ADDRESS OF FACILITY Framptom-Hawkins Funeral Home Federalsburg, MD 21632 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septic Shock Septic Shock DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Myocardial Infarction c. MYOCARDIAL INFARCTION d. ASCVD ASCVD Approximate Interval Between Onset and Death Hours? ~6 hrs | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALCOHOLISM Alcoholism | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Hubert L. Flery MD | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Hubert L. Flery MD | | | | 29c. LICENSE NUMBER D22773 | | 29d. DATE SIGNED (Month, Day, Year) 4/20/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) HUBERT L. FLERY MD 503 BYRN ST CAMBRIDGE MD 21613 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 25 '90 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) STEPHEN DECATUR Smoot | | | | 2. DATE OF DEATH MONTH DAY YEAR April 19, 1990 | | 3. TIME OF DEATH 6:45 A.M. | |
| 4. SOCIAL SECURITY NUMBER 214-42-8674 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 45 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 2, 1944 | |
| 8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA | | | | 9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH EASTON | |
| 9c. COUNTY OF DEATH TALBOT | | | | 10a. STATE MARYLAND | | | |
| 10b. COUNTY DORCHESTER | | | | 10c. CITY, TOWN OR LOCATION HURLOCK | | | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER WHITELY ROAD | | | |
| 10f. ZIP CODE 21643 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1963 - 1967 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 1 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONDUCTOR | | 16b. KIND OF BUSINESS/INDUSTRY RAILROAD | | | |
| 17. FATHER'S NAME (First, Middle, Last) ALEXANDER MEAD SMOOT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MADELYN BURGNER | | | |
| 19a. INFORMANT'S NAME (Type/Print) MELISSA BENNETT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) WHITELY ROAD, HURLOCK, MD 21643 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) EASTERN SHORE VETERANS CEM. | | 20c. LOCATION — City or Town, State BEULAH, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward D. Zeller</i> | | | | 22. NAME AND ADDRESS OF FACILITY ZELLER FUNERAL HOME EAST NEW MARKET, MD 21631 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → metastatic Squamous Carcinoma of the Hard Palate DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard W. M. M.D.</i> | | | | 29c. LICENSE NUMBER D 20507 | | 29d. DATE SIGNED (Month, Day, Year) 4/25/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J.W. GROSS 145 E. CARROLL ST SALISBURY M.D. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 25 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Hendricks</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARILYN Jane SOLT | | | | 2. DATE OF DEATH MONTH 4 DAY 16 YEAR 90 | | 3. TIME OF DEATH 4A M | |
| 4. SOCIAL SECURITY NUMBER 219-48-2407 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 44 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 08-10-1945 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington, DC | | | | 9a. FACILITY NAME (If not institution, give street and number) 401 Golf Course Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH Arnold | |
| 9c. COUNTY OF DEATH Anne Arundel | | | | 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION Arnold | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 401 Golf Course Drive | |
| 10f. ZIP CODE 21012 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Realtor | | 16b. KIND OF BUSINESS/INDUSTRY Real Estate Industry | | | |
| 17. FATHER'S NAME (First, Middle, Last) Jacob Minovitz | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha | | | |
| 19a. INFORMANT'S NAME (Type/Print) William A. Solt | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Golf Course Drive Arnold MD 21012 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MD Veterans Cemetery | | 20c. LOCATION — City or Town, State Crownsville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Barone</i> | | | | 22. NAME AND ADDRESS OF FACILITY 495 Ritchie Highway Barranco & Sons Severna Park, MD 21146 F.H. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Adenocarcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 18 months | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ernest W. Collier</i> | | | | 29c. LICENSE NUMBER D16354 | | 29d. DATE SIGNED (Month, Day, Year) 4/16/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 51 FRANKLIN ST ANNAPOLIS MD 21401 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 27 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 may be retained by the hospital or attending physician. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LOUISE K. SANTMYERS | | | | 2. DATE OF DEATH MONTH DAY YEAR APRIL 25, 1990 | | 3. TIME OF DEATH 10:25 A M | |
| 4. SOCIAL SECURITY NUMBER 219-20-1012 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 3, 1903 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE MARYLAND | |
| 9c. COUNTY OF DEATH ANNE ARUNDEL | | | | 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION Glen Burnie | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 452 Glen Mar Rd. Apt. 3-B | |
| 10f. ZIP CODE 21061 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | |
| 17. FATHER'S NAME (First, Middle, Last) (unknown) Albrecht | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie (unknown) | | | |
| 19a. INFORMANT'S NAME (Type/Print) James N. Santmyers | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 452 Glen Mar Rd. Apt. 3-B, Glen Burnie, MD 21061 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory | | 20c. LOCATION — City or Town, State Catons. Balto., MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSE | | | | 22. NAME AND ADDRESS OF FACILITY Kirkley Funeral Home 421 Crain Hwy. S.E., Glen Burnie, MD 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CRF / Acute renal failure Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF) CHF b. DUE TO (OR AS A CONSEQUENCE OF) ASCVD c. DUE TO (OR AS A CONSEQUENCE OF) ASCVD d. DUE TO (OR AS A CONSEQUENCE OF) ASCVD PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1. ASCVD 2. Asepsis | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER James N. Santmyers | | | | 29c. LICENSE NUMBER Q-19528 | | 29d. DATE SIGNED (Month, Day, Year) 4/26/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ELMO M. GAYOSO, M.D. 5411 FREDERICK ROAD BALTIMORE MARYLAND 21229 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 26 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Rodwell | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 90 13071 | | | |
|--|--|---|--|--|--|------------------------|--|--|--|-------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | | | |
| William Moore Smith | | | | Jan 23 90 | | | | 3:15 P M | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | | | |
| 577-46-8685 | | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | YRS. | | MONTHS DAYS HOURS MIN. | | Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | |
| 8508 Springvale Rd | | | | Silver Spring | | | | Montgomery | | | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | | | |
| Maryland | | Montgomery | | Silver Spring | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| 8508 Springvale Road | | | | 20901 | | | | U. S. A. | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | | | 14. RACE — American Indian, Black, White, etc. | | | |
| 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| Elementary/Secondary (0-12) College (1-4 or 5+) | | | | Administrator | | | | Federal Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | |
| William Ogden Smith | | | | Ruby Dempster | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| James Dempster | | | | 9303 Rockbrook Dallas, Texas 75220 | | | | | | | |
| 20a. METHOD OF DISPOSITION | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | | | 20c. LOCATION — City or Town, State | | | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | Homewood Cemetery | | | | Pittsburgh, Pennsylvania | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | |
| Michael P. Marzullo | | | | Marzullo Funeral Service 3981 Carrollton Road Upperco, Maryland 21155 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | | | |
| a. Acute Myocardial Dis. | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| b. Arteriosclerotic Cardio Vas. Dis. | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| c. | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| d. | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| Diabetes c bilrt amputated foot | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (Check only one) | | | | | | | |
| 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURED | |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | | M | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | |
| 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | John S. Rogers MD | | | | D09975 | | Jan, 23 1990 | |
| 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) | | | | | | | | | | | |
| John S. Rogers MD, 1919 Seminary Rd, Silver Spring Md. 20918 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |
| MAR 20 '90 | | | | Julia Davidson-Randall | | | | | | | |

17081 00

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR

REG NO

| | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) * Edna B. Smith | | | | 2. DATE OF DEATH MONTH DAY YEAR * 04 11 90 | | | | 3. TIME OF DEATH * 1:28 a m | | | | | |
| 4. SOCIAL SECURITY NUMBER 214- 09- 8585 | | | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 96 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 30, 1893 | | 8. BIRTHPLACE (State or Foreign Country) Boonsboro, Md. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) * Avalon Home Inc. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH * Hagerstown, | | | | 9c. COUNTY OF DEATH * Washington | | | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Washington | | | | 10c. CITY, TOWN OR LOCATION Hagerstown | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 110 N. Potomac St. | | | | 10f. ZIP CODE 21740 | | | | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 1 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | | | 16b. KIND OF BUSINESS/INDUSTRY Homemaking | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Caleb Long | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Fannie Mullendore | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lawrence J. Smith, | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Tedloe Lane, Knoxville, Tenn. 37920 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery | | 20c. LOCATION — City or Town, State Hagerstown, Md. 21740 | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE BAST FUNERAL HOME John H. Bast, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY 7606 Boonsboro Pike, Boonsboro, Md. | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { Coronary Atherosclerosis | | | | | | | | Approximate Interval Between Onset and Death 6 hrs yrs | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recent Gastro-intestinal bleeding Organic Brain Syndrome | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) None | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED None | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) None | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER W W L M | | | | 29c. LICENSE NUMBER D05967 | | | | 29d. DATE SIGNED (Month, Day, Year) 4-11-90 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 411 Division Avenue Hagerstown, Maryland 21740 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 17 '90 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | | | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

87031 00

Clara Isabelle Semler

90 13073

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Clara Isabelle Semler</u> | | | | 2. DATE OF DEATH MONTH <u>April</u> DAY <u>11</u> YEAR <u>1990</u> | | | | 3. TIME OF DEATH <u>10:25A</u> M | | | | | |
| 4. SOCIAL SECURITY NUMBER <u>214-09-4310</u> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) <u>85</u> YRS. | IF UNDER 1 YEAR MONTHS _____ DAYS _____ | | IF UNDER 24 HRS. HOURS _____ MIN. _____ | | 7. DATE OF BIRTH (Month, Day, Year) <u>July 26, 1904</u> | | 8. BIRTHPLACE (State or Foreign Country) <u>Pennsylvania</u> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Washington County Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Hagerstown</u> | | | | 9c. COUNTY OF DEATH <u>Washington</u> | | | | | |
| 10a. STATE <u>Maryland</u> | | 10b. COUNTY <u>Washington</u> | | 10c. CITY, TOWN OR LOCATION <u>Hagerstown</u> | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER <u>7 East Washington Street</u> | | | | 10f. ZIP CODE <u>21740</u> | | | | 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) _____ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u> | | | | 16b. KIND OF BUSINESS/INDUSTRY <u>Home</u> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Charles Hancock</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Lucy Faulders</u> | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Vernon L. Hancock</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>428 Stratford Avenue Hagerstown, Maryland 21740</u> | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Rose Hill Cemetery</u> | | | | 20c. LOCATION — City or Town, State <u>Hagerstown, Maryland</u> | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Gerald N. Minnich</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland</u> | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cardiopulmonary failure</u> Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <u>Respiratory failure</u> <u>Chronic obstructive pulmonary disease</u> <u>Pulmonary emphysema</u> | | | | | | | | | | Approximate Interval Between Onset and Death <u>25yrs</u> <u>7days</u> <u>2yrs</u> <u>ys</u> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Septic shock</u> <u>postoperative</u> <u>dehiscence</u> | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 25. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M _____ | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>RS [Signature]</u> | | | | | | 29c. LICENSE NUMBER <u>012426</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>4-13-90</u> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>RS [Signature] 323 W. [Signature] 102 Blvd [Signature]</u> | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>APR 16 '90</u> | | | | 32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

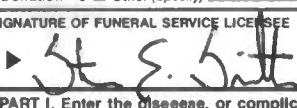

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13074

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Cameron Shoughh Sewell | | | | 2. DATE OF DEATH MONTH DAY YEAR April 27, 1990 | | 3. TIME OF DEATH 2:55 P.M. | |
| 4. SOCIAL SECURITY NUMBER 210-44-8617 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 36 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) August 19, 1953 PA. | |
| 9a. FACILITY NAME (If not institution, give street and number) 8970 Broomes Island Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Broomes Island | | 9c. COUNTY OF DEATH Calvert | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Calvert | | 10c. CITY, TOWN OR LOCATION Broomes Island | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 8907 Broomes Island Road | | | | 10f. ZIP CODE 20615 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Welder | | 18b. KIND OF BUSINESS/INDUSTRY Iron Industry | | | |
| 17. FATHER'S NAME (First, Middle, Last) Jay Edward Swell | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Partridge | | | |
| 19a. INFORMANT'S NAME (Type/Print) Stephanie Hanley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8179 Peebles Road, Pittsburg, PA 15239 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. LOCATION — City or Town, State Alexandria, Virginia | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Port Republic, Md. Rausch Funeral Home | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Suicide Gun shot to head DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 26a. DATE OF INJURY (Month, Day, Year) 4-27-90 | | 26b. TIME OF INJURY 5 P.M. | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5-1-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) I. Damalouji, M.D. Prince Frederick, Maryland | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 02 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be filled in by the attending physician and completely filed in by the funeral director, page 5 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

2013

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Frank Sherman, Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR 4-24-90 | | 3. TIME OF DEATH M 3:45PM | |
| 4. SOCIAL SECURITY NUMBER 216-54-7167 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 39 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-24-51 | |
| 9a. FACILITY NAME (If not institution, give street and number) Anne Arundel County General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Annapolis | | 9c. COUNTY OF DEATH Anne Arundel Co. | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Beech Anne | | 10c. CITY, TOWN OR LOCATION Chester | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER Rt #2 Box 612-0 | | | | 10f. ZIP CODE 21619 | | 10g. CITIZEN OF WHAT COUNTRY? U S A | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Secondary College (1-4 or 5+) Correctional officer | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frank Sherman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Willie Sherman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Vernetta Sherman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt #2 Box 612-0 Chester, Md. 21619 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Chester Union | | 20c. LOCATION — City or Town, State Chester, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bennie L. Smith | | | | 22. NAME AND ADDRESS OF FACILITY P.O. Box 928 Harlock, Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cranio-cerebral trauma DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation XX Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 4-24-90 | | 28b. TIME OF INJURY 3:00PM | |
| 28c. INJURY AT WORK? XX YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED Cable broke causing subject to fall from telephone pole | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Workplace | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 910 Windsor Avenue, Annapolis, MD | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] |
| 29c. LICENSE NUMBER OCME | | | | 29d. DATE SIGNED (Month, Day, Year) 4-25-90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julia C. Goodin, MD 111 Penn Street, Baltimore, MD 21201 vc | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 27 '90 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

AT 00 00

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Franklin Eugene Smith | | | | 2. DATE OF DEATH MONTH 4 DAY 16 YEAR 90 | | 3. TIME OF DEATH 4-31 A M | |
| 4. SOCIAL SECURITY NUMBER 218 20 0384 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4/17/'20 | |
| 8a. FACILITY NAME (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL | | | | 8b. CITY, TOWN OR LOCATION OF DEATH CLINTON | | 8c. BIRTHPLACE (State or Foreign Country) Maryland | |
| 10a. STATE Maryland | | | | 10b. COUNTY Charles | | 10c. CITY, TOWN OR LOCATION Waldorf | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 110 Ryon Court | | | |
| 10f. ZIP CODE 20601 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Skilled Laborer | | 16b. KIND OF BUSINESS/INDUSTRY Dept. of Public Works | | | |
| 17. FATHER'S NAME (First, Middle, Last) Howard Smith | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Hawkins | | | |
| 19a. INFORMANT'S NAME (Type/Print) Queen E. Smith | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Ryon Ct., Waldorf, Maryland 20601 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Asbury U. M. Ch. Cem | | 20c. LOCATION — City or Town, State Brandywine, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Marcell Adams | | | | 22. NAME AND ADDRESS OF FACILITY Adams Funeral Home, P.A. Aguasco Rd., Aquasco, MD. 20608 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → inattention Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. lung cancer b. due to (or as a consequence of): c. and sepsis d. due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER DR. HAIDAK |
| 29c. LICENSE NUMBER D-17605 | | | | | | | 29d. DATE SIGNED (Month, Day, Year) APR 26 '90 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. HAIDAK | | | | | | | 31. DATE FILED (Month, Day, Year) APR 26 '90 |
| 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, MORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. After this certificate has been signed by the attending physician and completely filled out, it must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the physician must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) William Henry Schlotzhauer | | | | 2. DATE OF DEATH MONTH April DAY 21 YEAR 90 | | 3. TIME OF DEATH 12:30 P.M. | |
| 4. SOCIAL SECURITY NUMBER 219-34-3211 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 53 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06 30 36 | |
| 9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH EASTON | | 9c. COUNTY OF DEATH TALBOT | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Talbot | | 10c. CITY, TOWN OR LOCATION Easton | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER Route 2, Box 228 | | | | 10f. ZIP CODE 21601 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Executive | | 16b. KIND OF BUSINESS/INDUSTRY exterminating | | | |
| 17. FATHER'S NAME (First, Middle, Last) Henry Adolph Schlotzhauer | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara B. Neal | | | |
| 19a. INFORMANT'S NAME (Type/Print) Rita S. Petitt | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Goldsborough Street, Easton MD 21601 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Paul's Church Cemetery Cordova, MD | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M. E. Newman | | | | 22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home Easton, Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic colon cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death 2 yr |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Stephen P. Carney | | | | 29c. LICENSE NUMBER 201225 | | 29d. DATE SIGNED (Month, Day, Year) 4-23-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen P. Carney, M.D. Rt 3 Box 106 Easton MD 21601 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 24 '90 | | 32. REGISTRAR'S SIGNATURE John Davidson | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

06 13017

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Allan W. Snyder | | | | 2. DATE OF DEATH MONTH DAY YEAR 4 26 1990 | | 3. TIME OF DEATH 3 A M | |
| 4. SOCIAL SECURITY NUMBER 217-38-9332 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 50 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-29-40 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 4812 Westfield Dr., | | 9b. CITY, TOWN OR LOCATION OF DEATH Hampstead, Md. | |
| 9c. COUNTY OF DEATH Carroll | | | | 10a. STATE Md. | | 10b. COUNTY Carroll | |
| 10c. CITY, TOWN OR LOCATION 4812 Westfield Dr. Hampstead | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 4812 Westfield Dr. | |
| 10f. ZIP CODE 21074 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College 5+ Teacher | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) School | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Oliver W. Snyder | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes E. Koch | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Linda Snyder | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4812 Westfield Dr., Hampstead, Md. 21074 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lakeview Mem. Park | | 20c. LOCATION — City or Town, State Sykesville, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven W. Elise | | | | 22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 934 S. Main St., Hampstead, Md. 21074 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Malignant Melanoma | | | | | | | 4 years |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER MD | | | | 29c. LICENSE NUMBER D33165 | | 29d. DATE SIGNED (Month, Day, Year) 4/26/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Steven Shaffer 21111 Annapolis Pike Hampstead Md 21074 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 26 '90 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It should be maintained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner should be notified at once.

05051 08



90 13079

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) James R. Satterfield | | | | 2. DATE OF DEATH MONTH 4 DAY 23 YEAR 90 | | 3. TIME OF DEATH 7:20 A M | |
| 4. SOCIAL SECURITY NUMBER 250-03-0137 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05-22-05 | |
| 8. BIRTHPLACE (State or Foreign Country) North Carolina | | | | 9a. FACILITY NAME (If not institution, give street and number) Pleasant View Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH Mt. Airy | |
| 9c. COUNTY OF DEATH Carroll | | | | 10a. STATE Maryland | | 10b. COUNTY Carroll County | |
| 10c. CITY, TOWN OR LOCATION Mt. Airy | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 4101 Baltimore National Pike | |
| 10f. ZIP CODE 21771 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cook | | 16b. KIND OF BUSINESS/INDUSTRY Restuarant | |
| 17. FATHER'S NAME (First, Middle, Last) Kenenth Satterfield | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Libby Slasiter | | | |
| 19a. INFORMANT'S NAME (Type/Print) Pleasant View Nursing Home | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4101 Baltimore National Pike Mt. Airy, MD 21771 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Springfield Cemetery | | 20c. LOCATION — City or Town, State Sykesville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian L. Haight | | | | 22. NAME AND ADDRESS OF FACILITY Haight Funeral Home (P.O. Box 195) Sykesville, MD 21784 (301)-795-1400 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Chronic lung disease DUE TO (OR AS A CONSEQUENCE OF): Dementia, left ventricular failure, 2nd ASD, serums, ulcer disease, bad osteoarthritis, history fractured hip | | | | | | Approximate Interval Between Onset and Death days yrs | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, left ventricular failure, 2nd ASD, serums, ulcer disease, bad osteoarthritis, history fractured hip | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DGA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Melvin K. Davidson MD | | | | 29c. LICENSE NUMBER 006588 | | 29d. DATE SIGNED (Month, Day, Year) 4/23/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Melvin K Davidson MD 200 Century Plaza Columbia MD 21046 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 1 90 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 13075

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Randall Lee Shaffer | | | | 2. DATE OF DEATH MONTH DAY YEAR 4-11-90 | | 3. TIME OF DEATH 11:31PM M | |
| 4. SOCIAL SECURITY NUMBER 218-64-7556 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 33 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Apr. 20, 1956 | |
| 9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH OAKLAND | | 9c. COUNTY OF DEATH GARRETT COUNTY | |
| 10a. STATE Maryland | | | | 10b. COUNTY Garrett | | 10c. CITY, TOWN OR LOCATION Oakland | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER Star Rt. 2 Box 259 | | | | 10f. ZIP CODE 21550 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Miner | | 16b. KIND OF BUSINESS/INDUSTRY Coal | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles T. Shaffer | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Mersing | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sandra K. Shaffer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Star Rt. 2 Box 259 Oakland, Maryland 21550 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Garrett Co. Memorial Gardens | | 20c. LOCATION — City or Town, State Oakland, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Franklin H. Custer | | | | 22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 South Second Street Oakland, MD 21550 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Crush injury to the chest and abdomen Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 4-11-90 | | 28b. TIME OF INJURY 9:30PM | | 28c. INJURY AT WORK? XX YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) coal mine | | 28e. DESCRIBE HOW INJURY OCCURRED Caught between wall of mine and moving equipment | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Mettiki Coal Mine, Rt. 3, Box 124A, Deer Park, Garrett County, MD | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 4-12-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAMES KAPLAN, MD 111 Penn Street, Baltimore, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 18 '90 | | 32. REGISTRAR'S SIGNATURE John David Foster | | | | | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

09001 02

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13081

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Sylvia E. Sparling | | | | 2. DATE OF DEATH MONTH DAY YEAR April 20, 1990 | | 3. TIME OF DEATH 7:15A M | |
| 4. SOCIAL SECURITY NUMBER 312 34 9442 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 96 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 02-24-1894 | |
| 8a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace | | 8c. BIRTHPLACE (State or Foreign Country) Indiana | |
| 10a. STATE MD | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Havre de Grace | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 451 Commerce Street | | | | 10f. ZIP CODE 21078 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 15b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph McNany | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ann Slonecker | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Jerome R. Johnson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 451 Commerce St., Havre de Grace, MD 21078 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Angel Hill Cemetery | | 20c. LOCATION — City or Town, State Havre de Grace, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrest Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Cholera c. d. Approximate Interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER P/2/90 | | 29d. DATE SIGNED (Month, Day, Year) ► 20 April 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Havre de Grace, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 20 '90 | | 32. REGISTRAR'S SIGNATURE | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Levada Oradell Sherrill | | | | 2. DATE OF DEATH MONTH DAY YEAR April 20, 1990 | | | | 3. TIME OF DEATH 8:20 AM | | | | | |
| 4. SOCIAL SECURITY NUMBER 213-74-2743 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 19, 1906 | | 8. BIRTHPLACE (State or Foreign Country) North Carolina | |
| 9a. FACILITY NAME (If not institution, give street and number) 801 Wiesser Court | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Joppa | | | | 9c. COUNTY OF DEATH Harford | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Joppa | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 801 Wiesser Court | | | | 10f. ZIP CODE 21085 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farm Wife | | | | 16b. KIND OF BUSINESS/INDUSTRY Farm | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) James --- Williams | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jane --- Woodard | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorothy S. Frisby | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Wiesser Ct., Joppa, Md. 21085 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cable Cove Cemetery | | | | 20c. LOCATION — City or Town, State Cable Cove, N. C. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. McComas III</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P. A. 1317 Cokesbury Rd., Abingdon, Md. 21009 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>respiratory arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>C.A.D.</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>anemia</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>renal failure 2° interstitial nephritis</i> <i>COPD</i> | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>David S. Dunn</i> | | | | | | 29c. LICENSE NUMBER D32295 | | | | 29d. DATE SIGNED (Month, Day, Year) 4/20/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID S. DUNN 1131 Belaire Rd | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 20 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>David S. Dunn</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BLANCH May Taylor Shaw | | | | 2. DATE OF DEATH MONTH DAY YEAR April 6, 1990 | | 3. TIME OF DEATH 5:45 A M | |
| 4. SOCIAL SECURITY NUMBER 227-40-8398 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-22-1897 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) PENINSULAR GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY | |
| 9c. COUNTY OF DEATH WICOMICO | | | | 10a. STATE Md. | | 10b. COUNTY Salisbury | |
| 10c. CITY, TOWN OR LOCATION Salisbury | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1503 Winthrop Place | |
| 10f. ZIP CODE 21801 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Homemaking | |
| 17. FATHER'S NAME (First, Middle, Last) William H. Taylor | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth May Moore | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mildred M. Douglas | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1503 Winthrop Place Salisbury, Md, 21801 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cape Charles Cemetery | | 20c. LOCATION — City or Town, State Cape Charles, Va. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mildred M. Douglas</i> | | | | 22. NAME AND ADDRESS OF FACILITY Wilkins-Doughty Funeral Home Cape Charles, Virginia 23310 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. due to (OR AS A CONSEQUENCE OF): b. due to (OR AS A CONSEQUENCE OF): c. due to (OR AS A CONSEQUENCE OF): d. due to (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>William H. Taylor</i> | | | | 29c. LICENSE NUMBER D29349 | | 29d. DATE SIGNED (Month, Day, Year) 4/6/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Robins CIVIC + RT 50 SALISBURY, MD. 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 11 90 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EDWIN SOMERS | | | | 2. DATE OF DEATH MONTH 4 DAY 13 YEAR 90 | | 3. TIME OF DEATH 7:00 P M | |
| 4. SOCIAL SECURITY NUMBER 217-07-7893 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jul. 21, 1914 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) ALICE BYRD TAWES NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH Crisfield, MD | |
| 9c. COUNTY OF DEATH Somerset | | | | 10a. STATE Maryland | | 10b. COUNTY Somerset | |
| 10c. CITY, TOWN OR LOCATION Crisfield, MD | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 313 Broadway | |
| 10f. ZIP CODE 21817 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W. W. II Army | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 9 College (14 or 5+) — | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contractor | | 16b. KIND OF BUSINESS/INDUSTRY Painting | |
| 17. FATHER'S NAME (First, Middle, Last) Cleveland Somers | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther M. Anderson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Beulah B. Somers | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10 a,b,c,d,e,f | | | |
| 20a. METHOD OF DISPOSITION 04-16-90 <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) American Legion Cemetery | | 20c. LOCATION — City or Town, State Crisfield, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert H. Bradshaw</i> | | | | 22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Advanced Parkinson's Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO Approximate Interval Between Onset and Death 5 Years | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>James A. Sterling, M.D.</i> | | 29c. LICENSE NUMBER D10214 | |
| 29d. DATE SIGNED (Month, Day, Year) 4/16/90 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James A. Sterling, M.D. - 320 W. Main St. - Crisfield, MD 21817 | | | |
| 31. DATE FILED (Month, Day, Year) APR 17 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Ray Raymond Snyder | | | | 2. DATE OF DEATH MONTH DAY YEAR 04 22 90 | | 3. TIME OF DEATH 2030 M | |
| 4. SOCIAL SECURITY NUMBER 236-46-2842 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8/15/1932 | |
| 8. BIRTHPLACE (State or Foreign Country) West Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) PENINSULA GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY, MARYLAND | |
| 9c. COUNTY OF DEATH WICOMICO | | | | 10a. STATE Delaware | | 10b. COUNTY Sussex | |
| 10c. CITY, TOWN OR LOCATION Dagsboro (Diamond acres) | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER Rt. 1 Box 93C | |
| 10f. ZIP CODE 19939 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) assist sup. - sanitation | | 16b. KIND OF BUSINESS/INDUSTRY food processing | |
| 17. FATHER'S NAME (First, Middle, Last) unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Snyder | | | |
| 19a. INFORMANT'S NAME (Type/Print) Buddy Ray Snyder | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Old Landing Road, Millsboro, Delaware 19966 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Millsboro Cemetery | | 20c. LOCATION — City or Town, State Millsboro, Delaware | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Frederick T. Watson | | | | 22. NAME AND ADDRESS OF FACILITY Watson Funeral Home, Inc. Millsboro, Delaware 19966 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral Death Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): SUBARACHNOID HEMORRHAGE WITH b. DUE TO (OR AS A CONSEQUENCE OF): ACUTE HYDROCEPHALUS c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WERE AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER J. O. A. M.D. | | | | 29c. LICENSE NUMBER D 19432 | | 29d. DATE SIGNED (Month, Day, Year) 4/22/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 560 Riverside Drive Salisbury, Md 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 4/22/90 | | 32. REGISTRAR'S SIGNATURE Julia Robinson-Rodell | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) DONALD Lee SCOTT | | | | 2. DATE OF DEATH MONTH DAY YEAR April 29, 1990 | | 3. TIME OF DEATH 1:20 A M | |
| 4. SOCIAL SECURITY NUMBER 218-24-8044 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 60 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 28, 1929 Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | | 9c. COUNTY OF DEATH Allegany | |
| 10a. STATE Maryland | | 10b. COUNTY Allegany | | 10c. CITY, TOWN OR LOCATION Cumberland | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 128 West Oldtown Road | | | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Never Employed | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Never Employed | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles P. Scott | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Washington | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Jean Cole | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Belvedere Rd. Harrisburg, Pa. 17109 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery | | 20c. LOCATION — City or Town, State Cumberland, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ernest A. Riley, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Leasure-Stein, Inc. 230 Baltimore Av. Cumberland, Md. 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ischemic Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Schizophrenia | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Qamar Zaman | | | | 29c. LICENSE NUMBER D23371 | | 29d. DATE SIGNED (Month, Day, Year) 4/30/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Qamar Zaman Memorial Hospital Medical Building, Cumberland, Md. 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 02 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CONDA SHIPLEY | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 - 04 - 1990 | | | | 3. TIME OF DEATH 7:39 P.M. M | | | | | |
| 4. SOCIAL SECURITY NUMBER 220104744 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) FEBRUARY 5 1906 | | 8. BIRTHPLACE (State or Foreign Country) PENNA. | |
| 9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND | | | | 9c. COUNTY OF DEATH ALLEGANY COUNTY | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ALLEGANY | | 10c. CITY, TOWN OR LOCATION CUMBERLAND | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 517 FECTIG AVENUE | | | | | | 10f. ZIP CODE 21502 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUT CONSTRICTION CO. | | | | 16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) LEVIN SHIPLEY | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY SCHETROMPF | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) JANET JOHNSON 1999 KELSEY DRIVE CUYAHOGA FALLS, OHIO 44221 | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BETHEL CEMETERY | | | | 20c. LOCATION — City or Town, State RFD#3 BEDFORD PA. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dale L. Merritt | | | | | | 22. NAME AND ADDRESS OF FACILITY SILCOX-MERRITT FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | Approximate interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | | | | | |
| a. CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| c. DIAPHRAGMATIC ARTERIOVENOUS FISTULA DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE RENAL DISEASE; Respiratory Inefficiency | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | | | 29c. LICENSE NUMBER D31875 | | | 29d. DATE SIGNED (Month, Day, Year) 5/5/90 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT WELIK, M.D. 921 SETON DRIVE CUMBERLAND, MD. 21502 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 07 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES OWEN SHERIDAN | | | | 2. DATE OF DEATH MONTH DAY YEAR April 29, 1990 | | 3. TIME OF DEATH 6:55 PM M | |
| 4. SOCIAL SECURITY NUMBER 212-62-7724 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 37 YRS. | 7. DATE OF BIRTH (Month, Day, Year) Aug. 21, 1952 | | 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | |
| 9a. FACILITY NAME (If not institution, give street and number) 1916 Harewood Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Edgewood | | 9c. COUNTY OF DEATH Harford | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Edgewood | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1916 Harewood Road | | | | 10f. ZIP CODE 21040 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Field Auditor | | 16b. KIND OF BUSINESS/INDUSTRY State Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Melvin James Sheridan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Mary Owen | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ruth M. Sheridan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2234 Tollgate Circle, Bel Air, MD. 21014 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Bel Air Memorial Gardens | | 20c. LOCATION — City or Town, State Bel Air, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. McComas III</i> | | | | 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Small Cell Lung</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 6 mo |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Arthur A. Serpick MD</i> | | | | 29c. LICENSE NUMBER D 10091 | | 29d. DATE SIGNED (Month, Day, Year) 4/30/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Arthur A. Serpick MD Saint Joseph Hosp Towson MD 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 01 '90 | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ELSIE R. STUMP | | | | 2. DATE OF DEATH MONTH DAY YEAR APRIL 30, 1990 | | 3. TIME OF DEATH 4:05AM M | |
| 4. SOCIAL SECURITY NUMBER 213-38-7352 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JUNE 14, 1896 | |
| 9a. FACILITY NAME (If not institution, give street and number) CALVERT MAONR NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH RISING SUN | | 9c. COUNTY OF DEATH CECIL | |
| 10a. STATE MARYLAND | | 10b. COUNTY CECIL | | 10c. CITY, TOWN OR LOCATION RISING SUN | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 106 MOUNT STREET | | | | 10f. ZIP CODE 21911 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SCHOOL TEACHER | | 16b. KIND OF BUSINESS/INDUSTRY PUBLIC SCHOOLS | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM REA | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) PIERCE | | | |
| 19a. INFORMANT'S NAME (Type/Print) GEORGE MCCULLOGH | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 OAK ROAD, GLEN FARMS, ELKTON, MD 21921 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BROOKVIEW CEMETERY | | 20c. LOCATION — City or Town, State RISING SUN, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY R.T. FOARD FNL HM, RISSING SUN, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic heart failure DUE TO (OR AS A CONSEQUENCE OF): D-S.C.V.D Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death 2 wks. 5 ym. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 0-11115 | | 29d. DATE SIGNED (Month, Day, Year) APR. 30, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. NEIL R. TAYLOR, JR. P.O. BOX 459, RISING SUN, MD 21911 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 1 '90 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES L. STEVENS | | | | 2. DATE OF DEATH MONTH DAY YEAR 4 - 24 - 90 | | 3. TIME OF DEATH 7:45 P.M. | |
| 4. SOCIAL SECURITY NUMBER 577-07-2660 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 18, 1913 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | 9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Bethesda | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Bethesda | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 5305 Camberley Avenue | | 10f. ZIP CODE 20814 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 7 Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Guard | | 16b. KIND OF BUSINESS/INDUSTRY Brinks Armored Car | |
| 17. FATHER'S NAME (First, Middle, Last) Bernard L. Stevens | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Blanche Thomas | | | |
| 19a. INFORMANT'S NAME (Type/Print) Paul L. Speakes | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5305 Camberley Ave., Bethesda, Md. 20814 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Hill Cemetery | | 20c. LOCATION — City or Town, State Fredericksburg, Va. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i> | | | | 22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): b. Refractory Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): c. Severe Coronary Artery disease. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John S. Kennedy</i> | | | | 29c. LICENSE NUMBER D22978 | | 29d. DATE SIGNED (Month, Day, Year) 4/25/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HIRSH D. KHIAJE, 19520 Doctor Ave, | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 26 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE AND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 of this certificate is to be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Harry Spack | | | | 2. DATE OF DEATH MONTH 4 DAY 17 YEAR 90 | | 3. TIME OF DEATH 2:45 P.M. | |
| 4. SOCIAL SECURITY NUMBER 068-24-4623 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-27-09 | |
| 8. BIRTHPLACE (State or Foreign Country) Boston, Mass. | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park | | 9c. COUNTY OF DEATH Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Silver Spring | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1220 East West Highway #114 | | | | 10f. ZIP CODE 20910 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 5-9-42---5-26-46 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Resturant Owner | | 16b. KIND OF BUSINESS/INDUSTRY Resturant | | | |
| 17. FATHER'S NAME (First, Middle, Last) Morris Spack | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Magnet | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joel Elman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4260 Loch Highland Parkway Roswell, Georgia 30075 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Suburban Crematory | | 20c. LOCATION — City or Town, State Silver Spring, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY W.H. Bacon Funeral Home 3447 14th Street, N.W. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chest Injuries DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Organic Brain Syndrome Metastatic Prostatic Carcinoma | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 4/17/90 | | 28b. TIME OF INJURY 11:45A | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) hospital | | 28e. DESCRIBE HOW INJURY OCCURRED Subject precipitated from hospital building 2nd fl. landing | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Washington Adventist Hosp., Takoma Park, Montg., Md. | | | | | | | |
| 29a. CERTIFIER (Check only) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 4/18/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julia C. Goodin, M.D. 111 Penn St. Baltimore, Md. 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 24 '90 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21201-3466

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for filing with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Richard V. Shores | | | | 2. DATE OF DEATH MONTH DAY YEAR 04 22 90 | | 3. TIME OF DEATH 1350 M | |
| 4. SOCIAL SECURITY NUMBER 212-40-8732 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 47 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-23-42 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) 202 Powell Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH Salisbury | |
| 9c. COUNTY OF DEATH Wicomico | | | | 10a. STATE MARYLAND | | 10b. COUNTY WICOMICO | |
| 10c. CITY, TOWN OR LOCATION SALISBURY | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 202 POWELL AVE. | |
| 10f. ZIP CODE 21801 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES AIR FORCE | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 14 YEARS College (1-4 or 5+) --- | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CORRECTIONAL OFFICER | | 16b. KIND OF BUSINESS/INDUSTRY LAW ENFORCEMENT | |
| 17. FATHER'S NAME (First, Middle, Last) EDDIE D. SHORES | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EDITH -- LASKER | | | |
| 19a. INFORMANT'S NAME (Type/Print) MURRAY SHORES | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1704 MT. HERMAN RD, SALISBURY, MD 21801 | | | |
| 20a. METHOD OF DISPOSITION 4/25/90 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ST. JOHN'S CEMETERY | | 20c. LOCATION — City or Town, State WENONA, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY HOLLOWAY FUNERAL HOME, PA 501 SNOW HILL RD, SALISBURY, MD 21801 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot Wound, Head DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home - 202 Powell Avenue | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Salisbury, Maryland | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Deputy M.E. | | | | 29c. LICENSE NUMBER D03599 | | 29d. DATE SIGNED (Month, Day, Year) 04-22-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John T. Bulkeley, M.D., 504 Elberta Ave., Salisbury, Md. 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 26 '90 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

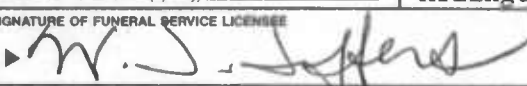
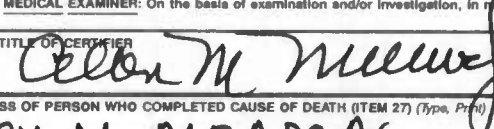
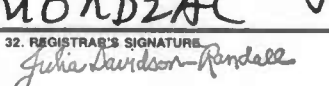
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SEP 01 00

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Ethel B. Toms | | | | 2. DATE OF DEATH MONTH DAY YEAR March 30 1990 | | 3. TIME OF DEATH 11:15 P. M. | |
| 4. SOCIAL SECURITY NUMBER 577-26-5465 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 17, 1923 | |
| 8a. FACILITY NAME (If not institution, give street and number) 25 E. Wayne Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Silver Spring | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 25 E Wayne Avenue | | | | 10f. ZIP CODE 20901 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Gov't Employee | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles A. Budd | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hallie Budd | | | |
| 19a. INFORMANT'S NAME (Type/Print) Hilda Carter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 827 Lapp CT. Rockford, Illinois 61101 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery | | 20c. LOCATION — City or Town, State Arlington, Virginia | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Frazier's Funeral Home 389 Rhode Island Avenue, N.W. Wash., D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. BREAST CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 9 YRS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D07990 MD | | 29d. DATE SIGNED (Month, Day, Year) 4/3/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Allen M Mondak 1175 - 19th St NW DC | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 19 '90 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) GLENN E. TURNER | | | | 2. DATE OF DEATH MONTH APRIL DAY 20 YEAR 1990 | | 3. TIME OF DEATH 1 P | |
| 4. SOCIAL SECURITY NUMBER 128-01-2715 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 1, 1901 | |
| 8a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie | | 8c. COUNTY OF DEATH Anne Arundel | |
| 9. RESIDENCE OF DECEDENT | | | | 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION Crofton | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 1737 Urby Drive | | | | 10f. ZIP CODE 21114 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tool Maker | | 16b. KIND OF BUSINESS/INDUSTRY Tool & Die Manufacturing | |
| 17. FATHER'S NAME (First, Middle, Last) Hezekiah A. Turner | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Maud Devine | | | |
| 19a. INFORMANT'S NAME (Type/Print) Elizabeth T. Darrow | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10. | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) South Street Cemetery | | 20c. LOCATION — City or Town, State Triangle, New York | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans, Pres. | | | | 22. NAME AND ADDRESS OF FACILITY Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → probable Ventricular Tachycardia Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div> probable myocardial infarction CARDIAC Arrhythmia (PAST) </div> <div> Approximate Interval Between Onset and Death 2-3 hr 2-3 hr </div> </div> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARDIAC Arrhythmia (PAST) | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Frank R. Jackson, MD | | | | 29c. LICENSE NUMBER D28874 | | 29d. DATE SIGNED (Month, Day, Year) 4/20/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANK R. JACKSON MD 3 VILLAGE GREEN, CROFTON, MD 21114 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 23 1990 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Henderson | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 4 & 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Edith Virginia Temple | | | | 2. DATE OF DEATH MONTH 04 DAY 15 YEAR 90 | | 3. TIME OF DEATH 10:30 AM | |
| 4. SOCIAL SECURITY NUMBER 578-10-1080 | | 6. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05/31/14 | |
| 9a. FACILITY NAME (If not institution, give street and number) Prince George's General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cheverly | | 9c. COUNTY OF DEATH Prince George's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Upper Marlboro | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 12610 Princeleigh Street | | | | 10f. ZIP CODE 20772 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Systems Analyst | | 15b. KIND OF BUSINESS/INDUSTRY Singer Link Company | | | |
| 17. FATHER'S NAME (First, Middle, Last) Kendall O'Dwyer | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Holmead | | | |
| 19a. INFORMANT'S NAME (Type/Print) Christina A. Badaczewski | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12610 Princeleigh Street, Upper Marlboro, MD 20772 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery | | 20c. LOCATION — City or Town, State Brentwood, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, Md 20781 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Respiratory Failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Acute Bronchitis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Chronic Obstructive Pulmonary Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <i>8 days</i> <i>8 days</i> <i>40 years</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 9 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 10 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D16410 | | 29d. DATE SIGNED (Month, Day, Year) ▶ | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gabriel B. Jaffe, MD 7500 Hanover Parkway #105, Greenbelt, Maryland 20770 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 23 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LUTHER REGINALD TARLETON | | | | 2. DATE OF DEATH MONTH DAY YEAR APRIL 18, 1990 | | 3. TIME OF DEATH 10:00 P.M. | |
| 4. SOCIAL SECURITY NUMBER 219-38-5600 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) AUG. 30, 1905 | |
| 8a. FACILITY NAME (If not institution, give street and number) AT HOME, NORTH TOWN CREEK DR. | | | | 8b. CITY, TOWN OR LOCATION OF DEATH CALIFORNIA | | 8c. COUNTY OF DEATH ST. MARY'S CO. | |
| 9. RESIDENCE OF DECEDENT | | | | 10. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10a. STATE MD. | | 10b. COUNTY ST. MARY'S CO. | | 10c. CITY, TOWN OR LOCATION CALIFORNIA | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10e. STREET AND NUMBER NORTH TOWN CREEK DR. | | 10f. ZIP CODE 20619 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7TH. GRADE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FARMER | | 16b. KIND OF BUSINESS/INDUSTRY FARM | | | |
| 17. FATHER'S NAME (First, Middle, Last) SAMUEL CLEVELAND TARLETON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MAGGIE JOSEPHINE PURCELL | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARY JOSEPHINE TARLETON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 66, CALIFORNIA, MD. 20619 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY FACE CEMETERY | | 20c. LOCATION — City or Town, State GREAT MILLS, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael K. Gardiner</i> | | | | 22. NAME AND ADDRESS OF FACILITY MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary Failure</i> | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| a. <i>Cardiopulmonary Failure</i> b. <i>Cardiomyopathy</i> c. <i>Carcinoma of Prostate</i> d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Patrick Jarboe, M.D.</i> | | | | 29c. LICENSE NUMBER D06419 | | 29d. DATE SIGNED (Month, Day, Year) 4-20-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. PATRICK JARBOE, M.D., LEONARDTOWN, MD. 20650 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 23 '90 | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Anna M. Tayman</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR April 15, 1990 | | 3. TIME OF DEATH 8:45 P. M. | |
| 4. SOCIAL SECURITY NUMBER 579-01-1382 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) January 12, 1916 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington, D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) 4310 Frank Street | | 9b. CITY, TOWN OR LOCATION OF DEATH Suitland | |
| 9c. COUNTY OF DEATH Prince George's | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George's | |
| 10c. CITY, TOWN OR LOCATION Suitland | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 4310 Frank St. | |
| 10f. ZIP CODE 20746 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary 8 Secondary (9-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | |
| 16b. KIND OF BUSINESS/INDUSTRY N/A | | 17. FATHER'S NAME (First, Middle, Last) William E. Miller | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Reese | | 19a. INFORMANT'S NAME (Type/Print) William H. Tayman | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4310 Frank St., Suitland, Maryland 20746 | | 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery | | 20c. LOCATION — City or Town, State Cheltenham, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i> | | 22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Maryland | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Breast Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | Approximate Interval Between Onset and Death 7 yrs | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Daniel M. Howell</i> | | 29c. LICENSE NUMBER D 02975 | |
| 29d. DATE SIGNED (Month, Day, Year) 4-16-90 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Daniel M. Howell, M.D. Charles Prof. Ctr., Box 20, Waldorf, Md. 20601 | | 31. DATE FILED (Month, Day, Year) APR 20 '90 | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARGARET -E- THURSTON | | | | 2. DATE OF DEATH MONTH DAY YEAR 4 - 15 - 1990 | | 3. TIME OF DEATH 2:05 AM | |
| 4. SOCIAL SECURITY NUMBER 188-16-4807 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 83 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 8-21-06 | | 8. BIRTHPLACE (State or Foreign Country) Hagerstown MD | |
| 9a. FACILITY NAME (If not institution, give street and number) Gros Venor Health Care Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Bethesda | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE MD | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Bethesda | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 5721, Gros Venor Lane Bethesda | | | | 10f. ZIP CODE MD 20814 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) — — — — — | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) School Teacher | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Roger T. Edmonds | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Funk | | | |
| 19a. INFORMANT'S NAME (Type/Print) Warren Thurston | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) U.S.S.A.H. Box 884, Washington, D.C. 20317 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Rose Hill Cemetery | | 20c. LOCATION — City or Town, State Hagerstown, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott Munnick | | | | 22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of The Lung DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John Tauber | | | | 29c. LICENSE NUMBER D08546 | | 29d. DATE SIGNED (Month, Day, Year) 4-15-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Tauber 8218 Wisconsin Ave Bethesda | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 17 90 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) RAYMOND VAN TASSEL | | | | 2. DATE OF DEATH MONTH DAY YEAR April 22, 1990 | | 3. TIME OF DEATH 10:05 A | |
| 4. SOCIAL SECURITY NUMBER 009-01-9341 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 09 26 06 | |
| 9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Easton | | 9c. COUNTY OF DEATH Talbot | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE VT. | | 10b. COUNTY Orleans | | 10c. CITY, TOWN OR LOCATION Westmore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER Route 1 | | | | 10f. ZIP CODE 05855 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) educator | | 16b. KIND OF BUSINESS/INDUSTRY education | | | |
| 17. FATHER'S NAME (First, Middle, Last) Walter Van Tassel | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Mueller | | | |
| 19a. INFORMANT'S NAME (Type/Print) Garton R. Van Tassel | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42 Knightsbridge Rd Easton MD 21601 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Eastern Shore Crematorium | | 20c. LOCATION — City or Town, State Georgetown DE | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>M. E. Newman III C.F.S.P.</i> | | | | 22. NAME AND ADDRESS OF FACILITY Newnam Funeral Home Easton, MD 21601 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Directly Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert J. McLean MD</i> | | 29c. LICENSE NUMBER D36411 | | 29d. DATE SIGNED (Month, Day, Year) 4/22/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT J. McLEAN MD 506 INGLEWICK AVE EASTON MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 24 90 | | 32. REGISTRAR'S SIGNATURE <i>John A. ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It is to be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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FOR STATE REGISTRAR Jack Albert Taylor **CERTIFICATE OF DEATH** REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|-------------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Jack ALBERT Taylor SR. | | | | 2. DATE OF DEATH MONTH DAY YEAR April 11 1990 2:15pm | | | | 3. TIME OF DEATH 2:15pm | | | |
| 4. SOCIAL SECURITY NUMBER 216-12-4409 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 12-25-1919 | | 8. BIRTHPLACE (State or Foreign Country) Washington DC | |
| 9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hosp. | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | | 9c. COUNTY OF DEATH Mont. | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 10120 New Hampshire Avenue | | | | | | 10f. ZIP CODE 20903 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 3 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942-1944 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) - | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter | | | | 16b. KIND OF BUSINESS/INDUSTRY Painting | | | |
| 17. FATHER'S NAME (First, Middle, Last) Jack E. Wilson | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie R. Miller | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Jack A. Taylor, Jr. | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2468 Quaker Ct., Waldorf, Md. 20602 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Huntt Crematory | | | | 20c. LOCATION — City or Town, State Waldorf, Md. | | | |
| 21. SIGNATURE OF FUNERAL HOME LICENSEE | | | | | | 22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home P. O. Box 156, Waldorf, Md. 20604-0156 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bronchial Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Cardio Pulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF): c. Gastro Intestinal Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | 29c. LICENSE NUMBER 009975 | | 29d. DATE SIGNED (Month, Day, Year) April 11, 1990 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 27 '90 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MD. 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 13101

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Harriet Tibbett | | | | 2. DATE OF DEATH MONTH DAY YEAR April 12, 1990 | | | | 3. TIME OF DEATH M | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 15, 1915 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 108 Midland Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie | | | | 9c. COUNTY OF DEATH Anne Arundal | | | |
| 10a. STATE Maryland | | 10b. COUNTY Anne Arundal | | 10c. CITY, TOWN OR LOCATION Glen Burnie | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 108 Midland Road | | | | 10f. ZIP CODE 21061 | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LPN | | 15b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles H. Green | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Stevenson | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sallie Dicus | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Midland Rd., Glen Burnie, Md. 21061 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Sunnyridge Cemetery | | 20c. LOCATION — City or Town, State Crisfield, Md. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James L. Henner</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home 127 Somerset Ave., Princess Anne, Md. | | | | | | | |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Endometrial Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Malnutrition</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Anemia</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death 9 Month | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph Buscema, MD</i> | | | | 29c. LICENSE NUMBER 025274 | | | | 29d. DATE SIGNED (Month, Day, Year) 4-19-90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 550 NORTH BROADWAY SUITE 409, BALI, MD 21205 Jos. BUSCEMA, MD | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 23 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be used for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13102

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) George W. Todd, Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR 4-9-90 | | 3. TIME OF DEATH 5:25p.m. | | | |
| 4. SOCIAL SECURITY NUMBER 216-16-4421 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06-26-16 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Edw.W.McCready Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Crisfield | | | 9c. COUNTY OF DEATH Somerset | | |
| 10a. STATE Maryland | | 10b. COUNTY Somerset | | 10c. CITY, TOWN OR LOCATION Crisfield | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 28 Maryland Ave. | | | | 10f. ZIP CODE 21817 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 8 | | 15b. COLLEGE (1-4 or 5+) -- | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor | | | 15b. KIND OF BUSINESS/INDUSTRY Oyster Propagation State of Maryland | | |
| 17. FATHER'S NAME (First, Middle, Last) George W. Todd | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian F. Parks | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Janet Todd | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 a b c d e f | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Sunnyridge Memorial Park | | 20c. LOCATION — City or Town, State Crisfield, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert H. Bunde | | | | 22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons, Main St., Crisfield, Md. | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis DUE TO (OR AS A CONSEQUENCE OF): Chronic Urinary Tract Infection Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Massive CV A DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 day 1 year 2 M | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Co of Prostatis Diabetes Mellitus | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER James A. Sterling, MD | | | | 29c. LICENSE NUMBER D10214 | | 29d. DATE SIGNED (Month, Day, Year) 4/10/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. James Sterling, Main St., Crisfield, Md. 21817 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 16 90 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

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29 Maryland Ave.

Operator Propagation
State of Maryland

Supervisor

Grade 3

William F. Latta

George W. Todd

Issued as a 10 x 5 x 5

James Todd

Crisfield, MD

Springfield Memorial Park

04-12-91

X

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Hilda M. Thompson | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-1-90 | | 3. TIME OF DEATH 2:52AM M | |
| 4. SOCIAL SECURITY NUMBER 216-22-6541 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 08-15-1912 MD | |
| 9a. FACILITY NAME (If not institution, give street and number) 5013 E. Preston Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| 10a. STATE MD | | 10b. COUNTY Baltimore City | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5013 East Preston Street | | | | 10f. ZIP CODE 21201 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ret. presser | | 16b. KIND OF BUSINESS/INDUSTRY Suit Manufacturer | | | |
| 17. FATHER'S NAME (First, Middle, Last) Silas Carder | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rhoda Agnes Deffinbaugh | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Carl F. Thompson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5013 East Preston Street Baltimore, MD | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Oldtown Cemetery | | 20c. LOCATION — City or Town, State Oldtown, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli | | | | 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arthritis | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO INSPECTION |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 5 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Julia C. Goodin, MD | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-1-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julia C. Goodin, MD 111 Penn Street, Baltimore, MD 21201 VC | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 04 1990 | | | | 32. REGISTRAR'S SIGNATURE John F. Scarpelli | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146
 TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Jeanette W. VanRoan | | | | 2. DATE OF DEATH MONTH DAY YEAR 4 13 90 | | 3. TIME OF DEATH 2:45 P M | |
| 4. SOCIAL SECURITY NUMBER 238-38-2252 | | 6. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 61 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 08-22-28 | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Maryland Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Clinton | | 9c. COUNTY OF DEATH P.G. County | |
| 10a. STATE Md. | | 10b. COUNTY P.G. | | 10c. CITY, TOWN OR LOCATION Clinton | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6414 Simmons Lane | | | | 10f. ZIP CODE 20735 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bank Manager | | 16b. KIND OF BUSINESS/INDUSTRY Banking | | | |
| 17. FATHER'S NAME (First, Middle, Last) Ernest Williams | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Blackwell | | | |
| 19a. INFORMANT'S NAME (Type/Print) John S. VanRoan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 355 Chapel Hill Dr. Prince Frederick Md 20678 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland State Veterans Cemetery Cheltenham, Maryland | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, MD 20735 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| Due to (or as a consequence of): Chronic Respiratory Failure Due to (or as a consequence of): Chronic Obstructive Lung Disease Due to (or as a consequence of): Cigarette Smoking | | | | | | | |
| SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Carcinoma of the Lung Coronary Heart Disease | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 6 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER D12906 | | 29d. DATE SIGNED (Month, Day, Year) 4/13/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8926 Woodyard Road # 602 Clinton, Maryland 20735 Louis Kaufman MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 19 '90 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | |
|---|--|--|----------------------------------|--|--|--|---|---|---|-----------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Catherine Bernedine VanJeune | | | | | | 2. DATE OF DEATH MONTH April DAY 15 , YEAR 1990 | | 3. TIME OF DEATH 6:00 P.M. | | | | |
| 4. SOCIAL SECURITY NUMBER 214-14-5129 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-01-1909 | | 8. BIRTHPLACE (State or Foreign Country) New York | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Reeders Memorial Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Boonsboro | | | 9c. COUNTY OF DEATH Washington | | | | | |
| 10a. STATE Maryland | | | 10b. COUNTY Washington | | | 10c. CITY, TOWN OR LOCATION Boonsboro | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 327 North Main Street | | | | | | 10f. ZIP CODE 21713 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8yrs. College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Resident Manager | | | 16b. KIND OF BUSINESS/INDUSTRY Retirement Center | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Henry Gelaise duBord | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lulu Gertrude Beasley | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Michael D. VanJeune | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 282 Warbler Court Hagerstown, Maryland 21740 | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery | | | 20c. LOCATION — City or Town, State Brentwood, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Douglas A. Fiery | | | | | | 22. NAME AND ADDRESS OF FACILITY 7606 Boonsboro Pike Bast Funeral Home Boonsboro, Maryland | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): b. coronary artery disease Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. d. | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER MD | | | | | | 29c. LICENSE NUMBER D32518 | | 29d. DATE SIGNED (Month, Day, Year) 4-16-90 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. R. Guedenet MD. 100 Geeting Lane Keedysville, Maryland 21756 | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 17 '90 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>William Allen Vincent</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>4 17 90</i> | | 3. TIME OF DEATH HOUR MIN. SEC. <i>1814 M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>220-28-6356</i> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>54</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>7/26/35</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Howard Co. MD.</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>Rte 1 Box 172A</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>LAUREL</i> | |
| 9c. COUNTY OF DEATH <i>AA</i> | | | | 10a. STATE <i>MARYLAND</i> | | | |
| 10b. COUNTY <i>ANNE ARUNDEL</i> | | | | 10c. CITY, TOWN OR LOCATION <i>LAUREL</i> | | | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER <i>ROUTE 1 BOX 172A</i> | | | |
| 10f. ZIP CODE <i>20707</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i> | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>JANITOR</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>MAINTENANCE</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>SIDNEY VINCENT</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>GRACE CAGER</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>VERONICA BRIDGES</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>MT ZION METHODIST CHURCH</i> | | 20c. LOCATION — City or Town, State <i>LAUREL, MD. 20707</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shirley C. Morton 618</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>HOFFMAN FUNERAL SERVICE 3605 14th ST N.W. WASH. D.C. 20010</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): <i>ASCVD</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Tuberculosis</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY HOUR MIN. SEC. <i>M</i> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>William P. Jones, M.D. Deputy</i> | | | | 29c. LICENSE NUMBER <i>DO6054</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>4-17-90</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>William P. Jones, M.D. 695 America Ct. 21035</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>APR 23 '90</i> | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Lucie Pearl Wastler</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR 4-13-90 | | 3. TIME OF DEATH 12:50pm M | |
| 4. SOCIAL SECURITY NUMBER 262-80-7787 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-21-02 | |
| 8. BIRTHPLACE (State or Foreign Country) N.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) Magnolia Garden Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH Lanham | |
| 9c. COUNTY OF DEATH P.G. | | | | 10a. STATE Md. | | 10b. COUNTY P.G. | |
| 10c. CITY, TOWN OR LOCATION Lanham | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 8200 Good Luck Road | |
| 10f. ZIP CODE 20706 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | |
| 16b. KIND OF BUSINESS/INDUSTRY Education | | 17. FATHER'S NAME (First, Middle, Last) Allen S. Carrington | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Reavis | | 19a. INFORMANT'S NAME (Type/Print) Lucille Lowe | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12701 Whiteholm Dr., Upper Marlboro, Md. 20772 | | 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Bayview Mem. Hwy Cemetery | | 20c. LOCATION — City or Town, State Pensacola, Fla. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerianne J. Bates</i> | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Md. | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>CARDIO RESPIRATORY DISTRESS</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>ADVANCED CHRONIC OBSTRUCTIVE PULMONARY DISEASE</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>ADVANCED SENILITY</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>MULTISTROKE DEMENTIA</i> <i>ATLANTIC HYPERTENSION</i> | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John M.</i> | | 29c. LICENSE NUMBER 016197 | |
| 29d. DATE SIGNED (Month, Day, Year) 4-13-90 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9322 Lanham-Southern Rd. Lanham, Md. 20706 | | 31. DATE FILED (Month, Day, Year) APR 17 '90 | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i> | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JESSE WOLF | | | | 2. DATE OF DEATH MONTH 04 DAY 06 YEAR 90 | | 3. TIME OF DEATH 1:04 pm M | | | | | |
| 4. SOCIAL SECURITY NUMBER 577 52 7671 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 53 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-20-1936 | | 8. BIRTHPLACE (State or Foreign Country) Washington D.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH BALTIMORE CITY | | | |
| 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Severn | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 7940 Trafalgar Court | | | | 10f. ZIP CODE 21144 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 59-64 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) ----- College (1-4 or 5+) 1 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Line Locator | | 16b. KIND OF BUSINESS/INDUSTRY Pepco | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Samuel Wolf | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Glasser | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Nancy Lee Wolf | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7940 Trafalgar Court Severn Maryland 21144 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) United Hebrew Cemetery | | 20c. LOCATION — City or Town, State Baltimore Maryland | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres | | | | 22. NAME AND ADDRESS OF FACILITY Beall-Evans Funeral Home, P.A. 16000 Annapolis Road Bowie Maryland 20715 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anemia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Acute gastro intestinal hemorrhage DUE TO (OR AS A CONSEQUENCE OF): c. Acute Myelogenous Leukemia DUE TO (OR AS A CONSEQUENCE OF): d. Myelodysplastic Syndrome | | | | | | | | Approximate Interval Between Onset and Death hours days months years | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Subdural hematoma | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER T.J. ... | | | | 29c. LICENSE NUMBER D38201 | | 29d. DATE SIGNED (Month, Day, Year) 4/6/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T.J. ... 604 N. Wolfe St Baltimore 21205 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 17 '90 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Hendall | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNKNOWN 90-53

ITEMS: 23 thru 28f per ME G-663

5-18-90 cm

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FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN DAVID WIECK | | | | 2. DATE OF DEATH MONTH DAY YEAR 4-9-90 | | 3. TIME OF DEATH 1:05AM M | | | | | |
| 4. SOCIAL SECURITY NUMBER 220 66 9235 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 25 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7-7-1964 | | 8. BIRTHPLACE (State or Foreign Country) Nevada | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Rt. 4 & 408 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Wayson's Corner Md. | | | 9c. COUNTY OF DEATH Anne Arundel County | | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Calvert | | 10c. CITY, TOWN OR LOCATION Chesapeake Beach | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 4005 Arcade Court | | | | 10f. ZIP CODE 20732 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk | | 15b. KIND OF BUSINESS/INDUSTRY Temps | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John E. Wieck | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Mei Wang | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) John E. Wieck | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4005 Arcade Court Chesapeake Beach Md. 20732 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lakemont Memorial Gardens | | 20c. LOCATION — City or Town, State Davidsonville Md. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans, Pres. | | | | 22. NAME AND ADDRESS OF FACILITY Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CLOSED HEAD INJURY AND THERMAL INJURY AND STAB WOUND OF ABDOMEN DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? XXX YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX YES 2 <input type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | 26. PLACE OF DEATH (Check only one) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 4-9-90 | | 28b. TIME OF INJURY 1:05am | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT STRUCK HIMSELF WHILE DRIVING CAR WHICH THEN CRASHED INTO A BUILDING AND CAUGHT FIRE | | | |
| 29a. CERTIFIER (Check only one) XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Mario F. Golle, Jr., MD | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 4-9-90 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore, MD 21201 | | | | | | | | 31. DATE FILED (Month, Day, Year) APR 17 '90 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR


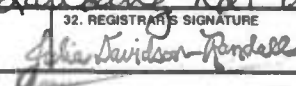
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary M. Walker | | | | 2. DATE OF DEATH MONTH 4 DAY 17 YEAR 90 | | 3. TIME OF DEATH 1:30 P.M. | |
| 4. SOCIAL SECURITY NUMBER 579-18-8975 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-9-17 | |
| 9a. FACILITY NAME (If not institution, give street and number) 9100 Spring Acres Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Clinton | | 9c. COUNTY OF DEATH P.G. | |
| 10a. STATE Md. | | | | 10b. COUNTY P.G. | | 10c. CITY, TOWN OR LOCATION Clinton | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 9100 Spring Acres Road | | | | 10f. ZIP CODE 20735 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Robert Morrison | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Pentz | | | |
| 19a. INFORMANT'S NAME (Type/Print) Burnis Walker | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10a-10f. | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lee Crematory | | 20c. LOCATION — City or Town, State Clinton, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Md. 20735 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PANCREATIC CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 1 YR. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. METASTATIC LIVER DISEASE ATHEROSCLEROTIC HEART DISEASE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Michael Y. Harris | | | | 29c. LICENSE NUMBER D28494 | | 29d. DATE SIGNED (Month, Day, Year) 4-19-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5506 Green Landing Rd. Upper Marlboro, Md. 20772 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 19 '90 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the hospital or attending physician. Page 7 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the hospital or attending physician.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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2. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Emma Withers</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>April 14, 1990</i> | | 3. TIME OF DEATH <i>5:55 P.M.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>579-01-7780</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>78</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>11-25-11</i> | |
| 8. FACILITY NAME (If not institution, give street and number) <i>Hyattsville, Md. 20908-2775 Ed. Hyatt, Sr.</i> | | | | 9a. CITY, TOWN OR LOCATION OF DEATH <i>Hyattsville</i> | | 9c. COUNTY OF DEATH <i>Pr. Geo.</i> | |
| 10a. STATE <i>Wash., D.C.</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>Washington, D.C.</i> | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>1106 McClough Ct., N.W.</i> | | | | 10f. ZIP CODE <i>20001</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (13-16) <i>5+</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Hair Dresser</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Private</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Robert Tillman</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mariah Audrey Fillman</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Renee Withers</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1106 McClough Ct., N.W. Wash., D.C. 20001</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Lincoln Cemetery</i> | | 20c. LOCATION — City or Town, State <i>Suitland, Md.</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lawrence M. Plunkett</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Plunkett Funeral Home 6010 Dix Street, N.E.</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pulmonary Edema</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>Chronic Renal Failure</i> <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Multiple Cerebrovascular Accidents, Anemia, Esophagitis, Multiple Upper GI Bleeds.</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stuart T. Tucker, M.D.</i> | | | | 29c. LICENSE NUMBER <i>D31001</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>4/14/90</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <i>Stuart T. Tucker, M.D. 7500 Greenway Ctr. Dr. Greenbelt, Md. 20770</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>APR 16 '90</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRAR Gertrude I. WARD

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Gertrude I WARD | | | | 2. DATE OF DEATH MONTH 4 DAY 24 YEAR 90 | | 3. TIME OF DEATH 7:04 AM | |
| 4. SOCIAL SECURITY NUMBER 216 30 2448 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-21-17 | |
| 8. BIRTHPLACE (State or Foreign Country) MD | | | | 9a. FACILITY NAME (If not institution, give street and number) Anne Arundel General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Annapolis | |
| 9c. COUNTY OF DEATH AA | | | | 10a. STATE MD | | 10b. COUNTY AA | |
| 10c. CITY, TOWN OR LOCATION Shady Side | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 1204 Spruce Ave. Cedarhurst | |
| 10f. ZIP CODE 20764 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) waitress | | 16b. KIND OF BUSINESS/INDUSTRY Restaurant | |
| 17. FATHER'S NAME (First, Middle, Last) Merton E. Marquess | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Annie Grierson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Gilbert L. Ward | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2260 Chalk Point Rd., West River, MD 20778 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Harmony UMC Cemetery | | 20c. LOCATION — City or Town, State Owings (Calvert) MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> RFA | | | | 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home Owings, MD 20736 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Congestive Heart Failure | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Mitral Regurgitation | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Dilated Cardiomyopathy | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> Wayne D. Burburn m | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 4/24/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILLED (Month, Day, Year) APR 27 1990 <i>[Signature]</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten text at the bottom of the page, possibly a signature or date.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) THADDEUS Allen WASTLER | | | | 2. DATE OF DEATH MONTH DAY YEAR APRIL 19, 1990 | | 3. TIME OF DEATH 11:05 p.m. | |
| 4. SOCIAL SECURITY NUMBER 261-36-9072 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 61 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 07-21-28 | | 8. BIRTHPLACE (State or Foreign Country) Selma, AL | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE CITY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Annapolis | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 679 H arness Creek View Drive | | | | 10f. ZIP CODE 21403 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES US Navy | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Oceanographer | | 16b. KIND OF BUSINESS/INDUSTRY US Gov't. EPA | | | |
| 17. FATHER'S NAME (First, Middle, Last) Thaddeus A. Wastler | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucie Carrington | | | |
| 19a. INFORMANT'S NAME (Type/Print) Linda C. Wastler | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 679 Harness Creek View Drive | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home P.A. 12 Ridgely Avenue, Annapolis, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | Hypotension | | | | Approximate Interval Between Onset and Death Days 2 | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | Overwhelming Infection | | | | Days | |
| | | Immuno compromised Patient | | | | Days | |
| | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| | | | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Brad Sherrill, MD</i> | | | | 29c. LICENSE NUMBER P1879 | | 29d. DATE SIGNED (Month, Day, Year) 4/19/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Brad Sherrill JHN Tower 110 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 4/19/90 | | 32. REGISTRAR'S SIGNATURE APR 23 1990 Julie Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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pp. 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

APR 11 1994

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN E. WOODFIELD | | | | 2. DATE OF DEATH MONTH DAY YEAR APRIL 19 1990 | | 3. TIME OF DEATH 206 AM | | |
| 4. SOCIAL SECURITY NUMBER 218-36-6379 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 53 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 6, 1936 | | |
| 9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE, MARYLAND | | 9c. COUNTY OF DEATH ANNE ARUNDEL | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Pasadena | | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | |
| 10e. STREET AND NUMBER Bello Machre | | | | 10f. ZIP CODE 21122 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Albert W. Woodfield | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Hopkins | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Louise Morris | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1567 B & A Blvd, Arnold, MD 21012 | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Woodfield Cemetery | | 20c. LOCATION — City or Town, State Galesville, MD | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald A. Lyf</i> | | | | 22. NAME AND ADDRESS OF FACILITY Taylor Funeral Chapel 147 Gloucester St., Annapolis, MD 21401 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute cardiac arrhythmia</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | |
| 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward N. Sherman M.D.</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 4-22-90 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EDWARD N. SHERMAN, M.D. 95 AQUAHART ROAD #203 GLEN BURNIE, MARYLAND 21061 | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 24 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Burnie</i> | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WEEMS, MALCOLM MALCOLM WEEMS | | | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 22 90 | | 3. TIME OF DEATH 850 P M | |
| 4. SOCIAL SECURITY NUMBER 215 12 1515 | | 5. SEX 1 X M 2 F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06/16/21 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) MARYLAND GENERAL HOSPITAL | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, MD | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 10e. STREET AND NUMBER 3800 W. BELVEDERE AVE BALTIMORE, MD 21215 | | | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES W.W.II, KOREAN | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SHOE REPAIRMAN | | 16b. KIND OF BUSINESS/INDUSTRY SELF EMPLOYED | | | |
| 17. FATHER'S NAME (First, Middle, Last) MALCOLM L. WEEMS | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ETHEL S. WEEMS | | | |
| 19a. INFORMANT'S NAME (Type/Print) ETHEL MURRAY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 HARLEM AVENUE BALTIMORE, MD. 21201 | | | | | |
| 20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BREWER HILL CEMETERY | | 20c. LOCATION — City or Town, State ANNAPOLIS, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i> | | | | 22. NAME AND ADDRESS OF FACILITY 821 WEST ST. ANNAPOLIS, MD. 21401 WILLIAM REESE & SONS MORTUARY, P.A. | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIOPULMONARY ARREST | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. PANCREATIC CARCINOMA | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 04/22/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRIAN J. EASTRIDGE 22 SOUTH GREENE ST. BALTIMORE, MD 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 25 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13116

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DELMAR HAHN WAREHIME | | | | 2. DATE OF DEATH MONTH DAY YEAR APR 17 1990 | | 3. TIME OF DEATH 0005AM | |
| 4. SOCIAL SECURITY NUMBER 219-12-2414 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) SEPT 7 1922 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9. COUNTY OF DEATH CARROLL | | | |
| 10. RESIDENCE OF DECEDENT | | | | 11. CITY, TOWN OR LOCATION OF DEATH WESTMINSTER | | | |
| 10a. STATE MD | | 10b. COUNTY Carroll | | 10c. CITY, TOWN OR LOCATION Westminster | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1929 Old Taneytown Road | | | | 10f. ZIP CODE 21157 | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager | | 16b. KIND OF BUSINESS/INDUSTRY Plumbing Store | | | |
| 17. FATHER'S NAME (First, Middle, Last) Paul R. Warehime | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Hahn | | | |
| 19a. INFORMANT'S NAME (Type/Print) Isabelle Harman Warehime | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1929 Old Taneytown Rd., Westminster, MD 21157 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Meadow Branch Cemetery | | 20c. LOCATION — City or Town, State Westminster, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert K. Pritts, Sr. | | | | 22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE LEUKEMIA DUE TO (OR AS A CONSEQUENCE OF): MYELOID DYSPLASIA Approximate Interval Between Onset and Death 2 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Daniel I. Welliver MD | | | | 29c. LICENSE NUMBER D11496 | | 29d. DATE SIGNED (Month, Day, Year) 4/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DANIEL I. WELLIVER 902 WASHINGTON ROAD WESTMINSTER MD 21157 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 23 '90 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 13117

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Edward Mason Welch | | | | 2. DATE OF DEATH MONTH DAY YEAR April 24, 1990 | | 3. TIME OF DEATH 1036 M | |
| 4. SOCIAL SECURITY NUMBER 577 46 6926 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 53 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1 31 37 | |
| 9a. FACILITY NAME (If not institution, give street and number) Calvert Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Prince Frederick | | 9c. COUNTY OF DEATH Calvert | |
| 10a. STATE Maryland | | | | 10b. COUNTY Calvert | | 10c. CITY, TOWN OR LOCATION Prince Frederick | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER P.O. Box 813 Lot 3 Pines Trailer Park | | | |
| 10f. ZIP CODE 20678 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1957-1969 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) electrician | | 16b. KIND OF BUSINESS/INDUSTRY construction | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles C. Welch | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary V. Huffman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joy F. Welch | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery | | 20c. LOCATION — City or Town, State Cheltenham Maryland PG | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE B. Rausch | | | | 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home 4405 Broomes Island Rd. Port Republic Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Respiratory failure Ventricular Tachycardia Cardiomegaly, Compensated | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M. Mathur, M.D. | | | | 29c. LICENSE NUMBER D-25735 | | 29d. DATE SIGNED (Month, Day, Year) 4/24/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. Mathur, M.D. Prince Frederick, Maryland | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 25 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

11161 06

90 13118

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Alice Cecelia Washington | | | | 2. DATE OF DEATH MONTH DAY YEAR April 20, 1990 | | 3. TIME OF DEATH P. M. 1:42 | |
| 4. SOCIAL SECURITY NUMBER 217 32 3716 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 53 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8/18/'36 | |
| 9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH La Plata | | 9c. COUNTY OF DEATH Charles | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Brandywine | | 10d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10e. STREET AND NUMBER 10708 Cedarville Road | | | | 10f. ZIP CODE 20613 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Leroy Bell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Simms | | | |
| 19a. INFORMANT'S NAME (Type/Print) William Washington | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10708 Cedarville Rd., Brandywine, MD. 20613 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Resurrection Cemetery | | 20c. LOCATION — City or Town, State Clinton, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martell O'lane | | | | 22. NAME AND ADDRESS OF FACILITY 20605 Agrano Rd Green md 20608 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIO-RESPIRATORY ARREST PULMONARY EMBOLISM Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Right sided pneumonia, Diabetes Mellitus | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Smishra | | | | 29c. LICENSE NUMBER D23021 | | 29d. DATE SIGNED (Month, Day, Year) 4/20/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sanjeeb Kumar Mishra, M.D. 7C Post Office Road Cenna Center Waldorf, Maryland 20602 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 26 '90 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Rodell | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be completed and filed in by the funeral director, or the hospital or attending physician, or the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the State. The law also requires that the death certificate be completed and filed in by the funeral director, or the hospital or attending physician, or the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the State.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20 13110

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Eugene Mills Winchester Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR 4-25-90 | | 3. TIME OF DEATH 11:35AM M | |
| 4. SOCIAL SECURITY NUMBER 216-80-5267 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 29 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-5-1961 | |
| 9a. FACILITY NAME (If not institution, give street and number) 147 W. Main Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Westminster | | 9c. COUNTY OF DEATH Carroll County | |
| 10a. STATE Maryland | | 10b. COUNTY Carroll | | 10c. CITY, TOWN OR LOCATION Westminster | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 147 W. Main Street | | | | 10f. ZIP CODE 21157 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician | | 16b. KIND OF BUSINESS/INDUSTRY Parlette Electric | | | |
| 17. FATHER'S NAME (First, Middle, Last) Eugene Mills Winchester Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Might Graham | | | |
| 19a. INFORMANT'S NAME (Type/Print) Margaret M. Graham | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 365 Pleasanton Rd. Westminster, Md. 21157 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation Services | | 20c. LOCATION — City or Town, State Hampstead, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Thomas D. Fletcher & Son Funeral Home 254 East Main St. Westminster, Md. 21157 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Contact shotgun wound of head a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) UKN. | | 28b. TIME OF INJURY UKN. M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) home | | 28d. DESCRIBE HOW INJURY OCCURRED Self inflicted | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 4-26-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James Kaplan, MD 111 Penn Street, Baltimore, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 27 '90 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MD 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Margaret Elizabeth WILLIAMS | | | | 2. DATE OF DEATH MONTH DAY YEAR April 2, 1990 | | 3. TIME OF DEATH 4:15 A. M. | |
| 4. SOCIAL SECURITY NUMBER 213-78-6936 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 79 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 2-25-1911 | | 8. BIRTHPLACE (State or Foreign Country) W. VA. | |
| 9a. FACILITY NAME (If not institution, give street and number) Garrett Co. Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH OakLAND | | 9c. COUNTY OF DEATH Garrett | |
| 10a. STATE Maryland | | 10b. COUNTY Garrett | | 10c. CITY, TOWN OR LOCATION Oakland | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1036 E. High St. | | | | 10f. ZIP CODE 21550 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Albert Saylor | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Wolfe | | | |
| 19a. INFORMANT'S NAME (Type/Print) John S. Williams | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1036 E. High St., Oakland, MD 21550 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Blooming Rose Cemetery | | 20c. LOCATION — City or Town, State Friendsville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Newman Funeral Homes, P.A. Grantsville, MD 21536 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. acute myocardial infarct DUE TO (OR AS A CONSEQUENCE OF): c. valvular heart dz DUE TO (OR AS A CONSEQUENCE OF): d. atherosclerosis Approximate Interval Between Onset and Death 1 wk 1 wk years years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD | | 29c. LICENSE NUMBER D26550 | | 29d. DATE SIGNED (Month, Day, Year) 4/2/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PO Box 486 Oakland, MD 21550 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 6 '90 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALTIMORE, MARYLAND 21203

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for filing within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Clarice P. Wood | | | | 2. DATE OF DEATH MONTH DAY YEAR 04 26 90 | | 3. TIME OF DEATH 2:00 P M | |
| 4. SOCIAL SECURITY NUMBER 212-20-3723 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-29-1907 | |
| 9a. FACILITY NAME (If not institution, give street and number) Citizens Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace | | 9c. COUNTY OF DEATH HARFORD | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Havre de Grace | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 114 Lapidum Road | | | | 10f. ZIP CODE 21078 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) (Ret) Secretary/Clerk | | 16b. KIND OF BUSINESS/INDUSTRY City Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Jesse A. Price | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lottie Gorrell | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Helen C. Wood | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 412, Havre de Grace, MD 21078 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Rock Run Cemetery | | 20c. LOCATION — City or Town, State Rock Run, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William J. Smith II | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Carcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Cancer of Lung DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BCAD | | | | | | | Approximate Interval Between Onset and Death |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dante Monakul | | | | 29c. LICENSE NUMBER 007644 | | 29d. DATE SIGNED (Month, Day, Year) 4/27/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DANTE MONAKUL Havre de Grace, MD 21078 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 27 '90 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

7

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. |
|--|--|--|--|---|--|---|--|---|--|----------|
| 1. DECEDENT'S NAME (First, Middle, Last) LULA P. Williams | | | | | | 2. DATE OF DEATH MONTH DAY YEAR APRIL 21, 1990 | | 3. TIME OF DEATH 0850 M | | |
| 4. SOCIAL SECURITY NUMBER 216-07-6311 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-27-1915 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | |
| 9a. FACILITY NAME (If not institution, give street and number) Peninsula General Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Salisbury, MD | | 9c. COUNTY OF DEATH Wicomico | | |
| 10a. STATE MD. | | 10b. COUNTY WICOMICO | | 10c. CITY, TOWN OR LOCATION SALISBURY | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 1514 RIVERSIDE DRIVE | | | | 10f. ZIP CODE 21801 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) AIDE | | 16b. KIND OF BUSINESS/INDUSTRY NURSING HOME | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIE PERDUE | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BEULAH TAYLOR | | | | |
| 19a. INFORMANT'S NAME (Type/Print) STANLEY WILLIAMS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1514 RIVERSIDE DR., SALISBURY, MD. 21801 | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ROCKAWALKIN CEM. | | 20c. LOCATION — City or Town, State HEBRON, MD. | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald E. Brown</i> | | | | 22. NAME AND ADDRESS OF FACILITY BOUNDS FUNERAL HOME, SALISBURY, MD. | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Respiratory failure 2-6 Pulmonary fibrosis year | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumothorax | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael...</i> | | | | | | 29c. LICENSE NUMBER 026612 | | 29d. DATE SIGNED (Month, Day, Year) 4-21-90 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. Crouch, Suite 7, Med Ctr, 105 Pitt Bluff Rd, Salisbury, MD 21801 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 23 '90 | | 32. REGISTRAR'S SIGNATURE <i>Julia...</i> | | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Beatrice Clara Wardell | | | | 2. DATE OF DEATH MONTH 4 DAY 7 YEAR 90 | | 3. TIME OF DEATH 7:50AM M | |
| 4. SOCIAL SECURITY NUMBER 219-07-4207 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 38 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3/11/52 | |
| 9a. FACILITY NAME (If not institution, give street and number) Eastern Shore State Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cambridge | | 9c. COUNTY OF DEATH Dorchester | |
| 10a. STATE Maryland | | | | 10b. COUNTY Wicomico | | 10c. CITY, TOWN OR LOCATION Salisbury | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER Route #2, Box 366, Jersey Road | | | | 10f. ZIP CODE 21801 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— H yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Afro-American | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) domestic | | 16b. KIND OF BUSINESS/INDUSTRY babysitting | | | |
| 17. FATHER'S NAME (First, Middle, Last) Thaddeus Wardell, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Susie Clara Conaway | | | |
| 19a. INFORMANT'S NAME (Type/Print) Susie C. Wardell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as above | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Green Acres Memorial Park | | 20c. LOCATION — City or Town, State Salisbury, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Loretta B. Jolley</i> | | | | 22. NAME AND ADDRESS OF FACILITY JOLLEY MEMORIAL CHAPEL, Rt. #2, Bbx 920, Jersey Rd, Salisbury, MD 21801 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary embolism DUE TO (OR AS A CONSEQUENCE OF): b. Deep vein thrombosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Obesity | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia C. Goodin, M.D.</i> | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 4/8/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julia C. Goodin, M.D. - Assistant 111 Penn St. Balto. MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 10 '90 | | 32. REGISTRAR'S SIGNATURE <i>Julia C. Goodin, M.D.</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13124

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) GEORGE EDWARD WALKO | | | | 2. DATE OF DEATH MONTH DAY YEAR APRIL 28 1990 | | 3. TIME OF DEATH 6:00 A M | |
| 4. SOCIAL SECURITY NUMBER 714-03-0438 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6-27-1913 | |
| 9a. FACILITY NAME (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH LA PLATA | | 9c. COUNTY OF DEATH CHARLES | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY CHARLES | | 10c. CITY, TOWN OR LOCATION INDIAN HEAD | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER RT. 1, BOX 111 | | | | 10f. ZIP CODE 20640 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WORLD WAR 2 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE College (1-4 or 5+) COLLEGE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MODEL MAKER | | 16b. KIND OF BUSINESS/INDUSTRY US GOVERNMENT | | | |
| 17. FATHER'S NAME (First, Middle, Last) UNAVAILABLE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNAVAILABLE | | | |
| 19a. INFORMANT'S NAME (Type/Print) JAMES M. WALKO | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RT 1, BOX 111, INDIAN HEAD MARYLAND 20640 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) THE HUNTT CREMATORY | | 20c. LOCATION — City or Town, State WALDORF, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Will Blumenthal</i> | | | | 22. NAME AND ADDRESS OF FACILITY THE HUNTT FUNERAL HOME, INC P.O. BOX 156, WALDORF, MARYLAND 20604-0156 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiovascular failure</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Due to (OR AS A CONSEQUENCE OF):</i> b. <i>Due to (OR AS A CONSEQUENCE OF):</i> c. <i>Due to (OR AS A CONSEQUENCE OF):</i> d. <i>Due to (OR AS A CONSEQUENCE OF):</i> | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coarctation</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>C. BANERJEE</i> | | | | 29c. LICENSE NUMBER DO9247 | | 29d. DATE SIGNED (Month, Day, Year) 4.28.90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) CHINMOY BANERJEE M.D., CHARLES PROFESSIONAL BUILDING SUITE 200 BOX 22 WALDORF MARYLAND 20601 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 01 '90 | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1346



90 13125

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Helen Georgiana Wilson | | | | 2. DATE OF DEATH MONTH DAY YEAR May 1, 1990 | | 3. TIME OF DEATH 10:50 p M | |
| 4. SOCIAL SECURITY NUMBER 214-05-8865 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 13, 1908 | |
| 9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital and Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | | 9c. COUNTY OF DEATH Allegany | |
| 10a. STATE Md. | | | | 10b. COUNTY Allegany | | 10c. CITY, TOWN OR LOCATION Cumberland | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 143 Polk St. | | | | 10f. ZIP CODE 21502 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bookkeeper | | 15b. KIND OF BUSINESS/INDUSTRY Soft Drink | | | |
| 17. FATHER'S NAME (First, Middle, Last) William R. Wilson | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Eva Litzenburg | | | |
| 19a. INFORMANT'S NAME (Type/Print) William R. Wilson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 605 Keyser, W. Va. 26726 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Rosedale Crematory | | 20c. LOCATION — City or Town, State Martinsburg, W. Va. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert C. Adams | | | | 22. NAME AND ADDRESS OF FACILITY Silcox-Merritt Funeral Service 404 Decatur St. Cumberland, Md. 21502 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Pulmonary arrest. DUE TO (OR AS A CONSEQUENCE OF): Liver mass DUE TO (OR AS A CONSEQUENCE OF): Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dysphagia Anemia | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Stephen Crossland | | 29c. LICENSE NUMBER D25296 | | 29d. DATE SIGNED (Month, Day, Year) 5/2/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Stephen Crossland 53 Greene Street, Cumberland, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 03 1990 | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

65.3 1.1

90-13126

Charles Williams

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CHARLES SIMPSON WILLIAMS | | | | 2. DATE OF DEATH MONTH 04 DAY 20 YEAR 90 | | 3. TIME OF DEATH 6:00 P M | | | |
| 4. SOCIAL SECURITY NUMBER 221-18-7189 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) DEC. 17, 1913 | | 8. BIRTHPLACE (State or Foreign Country) MISSOURI | |
| 9a. FACILITY NAME (If not institution, give street and number) Salisbury Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Salisbury | | | 9c. COUNTY OF DEATH Wicomico | | |
| 10a. STATE MARYLAND | | 10b. COUNTY WICOMICO | | 10c. CITY, TOWN OR LOCATION SALISBURY | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 46 BONHILL DRIVE | | | | 10f. ZIP CODE 21801 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES NAVY WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (1-4 or 5+) 7 YEARS | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) VICE PRESIDENT | | | 16b. KIND OF BUSINESS/INDUSTRY POULTRY DIVISION | | |
| 17. FATHER'S NAME (First, Middle, Last) IRVEN --- WILLIAMS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) WYLM --- BUCK | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) CHARLES K. WILLIAMS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 DUNBAR TERRACE, SALISBURY, MD 21801 | | | | | |
| 20a. METHOD OF DISPOSITION 4/23/90 <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) WICOMICO MEMORIAL PARK | | | 20c. LOCATION — City or Town, State SALISBURY, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY HOLLOWAY FUNERAL HOME, PA 501 SNOW HILL RD. SALISBURY, MD 21801 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiorespiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death Immediate | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multi-infarct Dementia Atherosclerotic Cerebrovascular Disease | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark Speake MD</i> | | | | 29c. LICENSE NUMBER D36708 | | 29d. DATE SIGNED (Month, Day, Year) 4-22-90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARK SPEAKE, MD RT. 50 & CIVIC AVE. SALISBURY MD. 21801 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 26 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00851 02

90-1633
ITEM: 27 per ME G-663
5-24-90 cm

90-13127

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|--|--|---|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Charles Young | | | | 2. DATE OF DEATH MONTH DAY YEAR 4 18 90 | | 3. TIME OF DEATH 8:04 P. M | | | | | |
| 4. SOCIAL SECURITY NUMBER 579-90-0614 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 25 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03/06/65 | | 8. BIRTHPLACE (State or Foreign Country) Washington D.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) John Hopkins Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | 9c. COUNTY OF DEATH | | | | |
| 10a. STATE MD. | | 10b. COUNTY Prince Georges' | | 10c. CITY, TOWN OR LOCATION Temple Hill | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 3335 27 th Avenue | | | | 10f. ZIP CODE 20784 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES 11/4/82-11/3/86 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Spec. | | 15b. KIND OF BUSINESS/INDUSTRY Private | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Johnny Pearson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ollie M. Young | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Patricia A. George | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4441 23 rd Parkway Apt. 202 District Hights MD. 20747 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cheltenham Cemetery | | 20c. LOCATION — City or Town, State Cheltenham MD. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James G. Neal Sr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home 7474 Landover Road, Landover, MD. 20785 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accidents 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 4-18-90 | | 28b. TIME OF INJURY 5:40P M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED subject jumped from viaduct | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) street | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Orleans Street, Balto., Md. | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>James G. Neal Sr.</i> | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 4-19-90 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James Kaplan, M.D. 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 23 90 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13128

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ALBERT ZDELLNER JR. | | | | 2. DATE OF DEATH MONTH 4 DAY 9 YEAR 1990 | | 3. TIME OF DEATH 10:25 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 263-38-9214 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8-18-1918 | | 8. BIRTHPLACE (State or Foreign Country) ALABAMA | | | |
| 9. FACILITY NAME (If not institution, give street and number) 801 N. DIVISION ST. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY | | | 9c. COUNTY OF DEATH WICOMICO | | | | |
| 10. RESIDENCE OF DECEDENT | | | | 10a. STATE MD. | | 10b. COUNTY WICOMICO | | 10c. CITY, TOWN OR LOCATION SALISBURY | | | |
| 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | | 10e. STREET AND NUMBER 801 NORTH DIVISION ST. | | 10f. ZIP CODE 21801 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES WWII - KOREA | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PIANO TECHNICIAN | | 16b. KIND OF BUSINESS/INDUSTRY SELF EMPLOYED | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) ALBERT ZDELLNER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CLARA RODENZ | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARTHA JEAN ZDELLNER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 N. DIVISION ST., SALISBURY, MD. 21801 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MD. VETERAN'S CEM. | | 20c. LOCATION — City or Town, State HURLOCK, MD. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE B. Keith Phipps | | | | 22. NAME AND ADDRESS OF FACILITY BOUNDS FUNERAL HOME, SALISBURY, MD. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Cancer Metastasis to Brain | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 YES 2 NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER E. Evangelista M.D. | | 29c. LICENSE NUMBER 737670 | | 29d. DATE SIGNED (Month, Day, Year) 4/10/90 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. E. M. Evangelista | | | | 31. DATE FILED (Month, Day, Year) APR 10 1990 | | | | 32. REGISTRAR'S SIGNATURE John D. ... | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) HELEN TOWNSLEY ALLEN | | | | 2. DATE OF DEATH MONTH DAY YEAR May 11 90 | | 3. TIME OF DEATH 0330 AM | |
| 4. SOCIAL SECURITY NUMBER 577-84-4190 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 95 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9 May 1895 | |
| 9a. FACILITY NAME (If not institution, give street and number) KESWICK HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE D.C. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION WASHINGTON | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10a. STREET AND NUMBER 3133 CONNECTICUT AVE. | | | | 10f. ZIP CODE 20008 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) CLARENCE PAGE TOWNSLEY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARIAN HOWLAND | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. MARIAN A. BROWNE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 MARGATE ROAD LUTHERVILLE, MD. 21293 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MT. CREMATORY | | 20c. LOCATION — City or Town, State BALTIMORE, MD. 21202 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. H. Ruth | | | | 22. NAME AND ADDRESS OF FACILITY 4905 YORK ROAD 21212 H.W. JENKINS AND SONS CO. BALTO. MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 3 mins years. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alz - Dementia Chronic Venous Stasis Ulcerations | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Joseph W. Zerbley MD | | 29c. LICENSE NUMBER D 22334 | | 29d. DATE SIGNED (Month, Day, Year) 11 May 90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph W. Zerbley MD 700 W 40th Street Balto 21212 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | 32. REGISTRAR'S SIGNATURE John B. ... | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CS (R) 02

90 13130

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEASED'S NAME (First, Middle, Last) AKA - HILDA VIRGINIA AMBROSE VIRGINIA HILDA AMBROSE | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 12 90 | | 3. TIME OF DEATH 9:05am M | |
| 4. SOCIAL SECURITY NUMBER 212-42-9223 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7-22-15 | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital 900 S. Caton Ave | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, Md 21229 | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEASED | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Lansdowne | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2408 Brunswick Road | | | | 10f. ZIP CODE 21227 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6th grade | | | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Ebenezer Gosnell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Myrtle Cooper | | | |
| 19a. INFORMANT'S NAME (Type/Print) Tana Wickless | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2426 Saratoga Ave. Baltimore, MD 21227 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park | | 20c. LOCATION — City or Town, State Elkridge, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Tana Wickless</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. End stage Cor pulmonale, CHF b. COPD c. d. Sequitally ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypernatremia, Acute, moderate</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mayor and Resident</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) N. MAYUR MD ST Agnes Hospital Baltimore, MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR <i>Juba Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HENRY TREMONT BAKER | | | | | | 2. DATE OF DEATH MONTH 5 DAY 10 YEAR 90 2:00 am | | 3. TIME OF DEATH 2:00 am | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-01-1913 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 84 YRS. | IF UNDER 1 YEAR MONTHS _____ DAYS _____ | | IF UNDER 24 HRS. HOURS _____ MIN. _____ | | 7. DATE OF BIRTH (Month, Day, Year) 10-21-05 | | 8. BIRTHPLACE (State or Foreign Country) MD. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, CITY | | | 9c. COUNTY OF DEATH | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION TOWSON | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 336 STEVENSON LANE | | | | | | 10f. ZIP CODE 21204 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| Elementary/Secondary (0-12) 12 | | College (1-4 or 5+) 1 | | REAL ESTATE BROKER | | | | REAL ESTATE | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) HENRY J. BAKER | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) KATHARINE NOREANO ZELL | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) ELVA THOMAS BAKER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 336 STEVENSON LANE TOWSON, MD. 21204 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEM. | | | | 20c. LOCATION — City or Town, State BALTIMORE, MD. 21229 | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. V. Butler | | | | | | 22. NAME AND ADDRESS OF FACILITY 4905 YORK ROAD. 21212 H.W.JENKINS AND SONS CO. BALTO.MD. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → stroke Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { CAD → MI + AF. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) GSH. | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Wail Amy PAXI | | | | | | 29c. LICENSE NUMBER | | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wail Amy GSH. | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 5 MAY 14 1990 | | | | | | | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>MRS ETHEL BELL</i> | | | | 2. DATE OF DEATH MONTH <i>5</i> - DAY <i>5</i> - YEAR <i>90</i> | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER <i>215-18-5980</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>73</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>9-24-1916</i> | |
| 8a. FACILITY NAME (If not institution, give street and number) <i>3414 Woodbrook Ave.</i> | | | | 8b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i> | | 8c. COUNTY OF DEATH | |
| 9a. STATE <i>Maryland</i> | | 9b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10a. STREET AND NUMBER <i>3414 Woodbrook Ave.</i> | | | | 10f. ZIP CODE <i>21217</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>RETIRED</i> | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Andrew J. Montgomery</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary E. Montgomery</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Shirley Conney</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2927 Oakley Ave. Baltimore Md. 21215</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Woodlawn Cem.</i> | | 20c. LOCATION — City or Town, State <i>BALTO. CO. Md.</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Joseph L. Russ Funeral Home 2222 W. North Ave. Balt. Md. 21216</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Atherosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Perceval A. Smith, M.D.</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>5-7-90</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>2600 Liberty Heights Ave. Baltimore, Md. 21215</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 14 1990</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BAKER E. MARGARET | | | | 2. DATE OF DEATH MONTH 5 DAY 9 YEAR 90 | | 3. TIME OF DEATH 1:20 PM | |
| 4. SOCIAL SECURITY NUMBER 21734 2826 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-1-12 | |
| 9a. FACILITY NAME (If not institution, give street and number) CHURCH HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore Md. | | 9c. COUNTY OF DEATH | |
| 10a. STATE Md. | | | | 10b. COUNTY Md. | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 4102 Asbury Ave. | | | | 10f. ZIP CODE 21236 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 years | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 17. KIND OF BUSINESS/INDUSTRY Homemaking | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Franklin Boughter | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lottie Barbour | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Jane A. Carneal | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4102 Asbury Avenue Baltimore, Md. 21236 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lassahn Funeral Home Inc. | | | | 22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Balto., Md. 21236 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PULMONARY EMBOLISM, Acute DUE TO (OR AS A CONSEQUENCE OF): Severe COPD Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST LLL infarcted closure, ATRIOLECTATIC LABOR ASCENDING ULCER, SACRAL AREA. | | | | | | Approximate Interval Between Onset and Death Hours > 10 years 6 months 2 hours | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - severe depression. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) N/A | | 28b. TIME OF INJURY N/A | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Albert Nahum MD | | | | 29c. LICENSE NUMBER B 69648 | | 29d. DATE SIGNED (Month, Day, Year) 5.9.90 | |
| 30. NAME AND ADDRESS OF PERSON COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Albert Nahum 100 Broadway Church Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE Johanna... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Conrad Bartenfetter | | | | 2. DATE OF DEATH MONTH 5 DAY 10 YEAR 90 | | 3. TIME OF DEATH 225 P M | |
| 4. SOCIAL SECURITY NUMBER 219 07 3950 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10/26/96 | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Joseph Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Balto. | |
| 10a. STATE md | | | | 10b. COUNTY Balto. | | 10c. CITY, TOWN OR LOCATION Balto. | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 7715 Babikow Road | | | |
| 10f. ZIP CODE 21237 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW 1 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 years College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer | | 16b. KIND OF BUSINESS/INDUSTRY Self-Employed | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Bartenfelter | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Becker | | | |
| 19a. INFORMANT'S NAME (Type/Print) John Bartenfelter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3013 Edgewood Avenue Balto., Md. 21234 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery | | 20c. LOCATION — City or Town, State Balto., Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Josephine Dureau Home | | | | 22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Balto., Md. 21236 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Renal Insufficiency DUE TO (OR AS A CONSEQUENCE OF): Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Periphereal Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Richard L. Linthicum MD | | | | 29c. LICENSE NUMBER D31826 | | 29d. DATE SIGNED (Month, Day, Year) 5-10-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard L. Linthicum MD Saint Josephs Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146


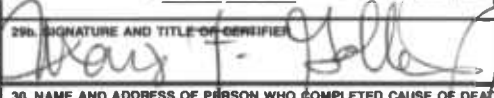

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Helen (NMI) Bogusko | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-8-90 | | 3. TIME OF DEATH 4:15AM M | |
| 4. SOCIAL SECURITY NUMBER 209-16-2422 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-1-1924 | |
| 8. BIRTHPLACE (State or Foreign Country) Plains, Pa. | | | | 9a. FACILITY NAME (If not institution, give street and number) St. Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | |
| 9c. COUNTY OF DEATH Baltimore County | | | | 10a. STATE Md. | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Lutherville, Md. | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 15 Atherton Rd. | |
| 10f. ZIP CODE 21093 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) Unknown | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Home | |
| 17. FATHER'S NAME (First, Middle, Last) John F. Goobic, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Stchur | | | |
| 19a. INFORMANT'S NAME (Type/Print) Edward A. Bogusko | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Atherton Rd. Lutherville, Md. 21093 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Crematory | | 20c. LOCATION — City or Town, State Balto., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd. Dundalk, MD. 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Carcinoma of breast and uterus | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? XXX YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-8-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mario F. Golle, Jr., MD 111 Penn Street, Baltimore, MD 21201 vc | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HOWARD R. BURROUGHS | | 2. DATE OF DEATH MONTH DAY YEAR MAY 10 1990 | | 3. TIME OF DEATH 1230A | |
| 4. SOCIAL SECURITY NUMBER 212-09-8623 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) 7/2/09 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) INNS OF EVERGREEN - SOUTH | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1820 Spence Street Apt. #314 | | 10f. ZIP CODE 21230 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th grade College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sewing Machine Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY Singer, Inc. | |
| 17. FATHER'S NAME (First, Middle, Last) Steven Burroughs | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Amelia Krause | | | |
| 19a. INFORMANT'S NAME (Type/Print) Cecelia L. Burroughs | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1820 Spence St. Apt. 314 Baltimore, MD 21230 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. LOCATION — City or Town, State Brooklyn Pk, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | 22. NAME AND ADDRESS OF FACILITY Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Respiratory Failure b. Due to (or as a consequence of) Carcinoma of the lung & Metastasis c. ASCD d. Due to (or as a consequence of) ASCVD | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. copd | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | 29c. LICENSE NUMBER D22645 | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FREDRIC S. SIKES 7151 HOLABIRD AVE.; BALTO. MD. 21222 | | | | | |
| 31. DATE FILLED (Month, Day, Year) MAY 14 1990 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

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ITEM:14 per HOSPITAL G-663
5-31-90 cm

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FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. XC 047 11 868

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM EDWARD BELL | | 2. DATE OF DEATH MONTH DAY YEAR MAY 7, 1990 | | 3. TIME OF DEATH 8:20 A. | |
| 4. SOCIAL SECURITY NUMBER 164 18 3960 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) JUNE 5, 1906 | | 8. BIRTHPLACE (State or Foreign Country) VIRGINIA | | | |
| 9a. FACILITY NAME (If not institution, give street and number) VA MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH FORT HOWARD | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 812 WHITMORE AVENUE | | 10f. ZIP CODE 21216 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE BLACK | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER | | 16b. KIND OF BUSINESS/INDUSTRY | | 17. FATHER'S NAME (First, Middle, Last) WILLIAM BELL | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE BRANCH | | 19a. INFORMANT'S NAME (Type/Print) CLINICAL RECORDS, VAMC | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9600 NORTH POINT ROAD FORT HOWARD, MARYLAND 21052 | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) NdVa Cemetery Crownsville, Md | | 20c. LOCATION — City or Town, State Crownsville, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | 22. NAME AND ADDRESS OF FACILITY 1712 W. North Ave Baltimore, Md | | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → c. CARCINOMA OF PROSTATE WITH METASTASIS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ORGANIC MENTAL DISORDER | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) MAY 7, 1990 | |
| 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | 29c. LICENSE NUMBER | |
| 29d. DATE SIGNED (Month, Day, Year) MAY 7, 1990 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER V. JUVAN, M.D. VA MEDICAL CENTER FORT HOWARD, MARYLAND 21052 | | 31. DATE OF DEATH (Month, Day, Year) MAY 14 1990 | |
| 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

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MD 8V6M

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Handwritten signature

90 13138

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|--|--|---|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JESSIE PEARL CREEK | | | | 2. DATE OF DEATH MONTH DAY YEAR May 9, 1990 | | 3. TIME OF DEATH 1:40 PM M | | |
| 4. SOCIAL SECURITY NUMBER 215-26-0820 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 97 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 28, 1892 | | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | 9a. FACILITY NAME (If not institution, give street and number) 1508 Southview Road | | 9b. CITY, TOWN OR LOCATION OF DEATH Bel Air | | 9c. COUNTY OF DEATH Harford | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Bel Air | | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1508 Southview Road | | 10f. ZIP CODE 21014 | | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) School Teacher | | 16b. KIND OF BUSINESS/INDUSTRY County | | |
| 17. FATHER'S NAME (First, Middle, Last) George (nmn) Hoopengardner | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Ann Northcraft | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Betty J. Bryant | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1508 Southview Rd. Bel Air, Maryland 21014 | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Buck Valley Christian Cemetery, Warfordsburg, Pa. | | 20c. LOCATION — City or Town, State | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Grove Funeral Home 141 West Main Street Hancock, Md. 21750 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>CARDIAC ARREST</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>ATHEROSCLEROSIS</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Old age</u> | | | | | | | Approximate Interval Between Onset and Death | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D7644 | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DANTE MONAKIL MD 1400 E. Grace Rd 21078 | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13139

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DORSEY | | | | 2. DATE OF DEATH MONTH 5 - DAY 11 - YEAR 90 | | | | 3. TIME OF DEATH 5:15 A.M. | |
| 4. SOCIAL SECURITY NUMBER 218-037109 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2-19-08 | | 8. BIRTHPLACE (State or Foreign Country) BALTO. MD. | |
| 9a. FACILITY NAME (If not institution, give street and number) Liberty Med Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 123 W. 29th Street | | | | 10f. ZIP CODE 21218 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | |
| 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired | | | | 15b. KIND OF BUSINESS/INDUSTRY | | | | 16. FATHER'S NAME (First, Middle, Last) Marshall W. Dorsey | |
| 16a. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Lee Waters | | | | 17. INFORMANT'S NAME (Type/Print) Mrs. Elizabeth Kearns | | | | 17b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2850 GARRISON AVE. | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Garden of Eternal Hope | | | | 20c. LOCATION — City or Town, State Finksburg, C. Co. Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ | | | | 22. NAME AND ADDRESS OF FACILITY 65 EPH L. Russ Funeral Home 2222 W. North Ave. Balto. Md 21216 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Asphyxiation DUE TO (OR AS A CONSEQUENCE OF): b. Left pleural effusion DUE TO (OR AS A CONSEQUENCE OF): c. Lung cancer DUE TO (OR AS A CONSEQUENCE OF): d. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Khaled Al-Kabi MD | | | | 29c. LICENSE NUMBER D35728 | | | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Khaled Al-Kabi Liberty Medical Center | | | | 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CCP 01

90 13140

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>ANNA R. EURICE</u> | | | | 2. DATE OF DEATH MONTH DAY YEAR <u>5-9-90</u> | | 3. TIME OF DEATH <u>9:55</u> ^A _M | |
| 4. SOCIAL SECURITY NUMBER <u>216-52-1235</u> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs., last birthday) <u>83</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>8-15-06</u> | |
| 8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u> | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>MFL - Eastern Ave</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u> | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <u>Maryland</u> | | 10b. COUNTY <u>Baltimore</u> | | 10c. CITY, TOWN OR LOCATION <u>Middle River</u> | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <u>10236 Bird River Rd.</u> | | | | 10f. ZIP CODE <u>21220</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>Wht</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>7th</u> College (1-4 or 5+) <u></u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Home maker</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>Homemaking</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Joseph P. Tremper</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Margaret Kahl</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Alberta M. Gambrill</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>10416 Vincent Farm Rd. White Marsh, Md. 21162</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Holly Hill Memorial Park</u> | | 20c. LOCATION — City or Town, State <u>Baltimore, Maryland</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Lassahn Funeral Home</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Lassahn Funeral Home</u> <u>7401 Belair Rd. Balto., Md. 21236</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>18% 2nd + 3rd degree burns.</u> | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): <u>Dementia</u> | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): <u>Cardiac Arrhythmias/Myocardial</u> | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): <u></u> | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): <u></u> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ischem - JTI - HTN - MRSA ⊕</u> <u>w/o DVT</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>W.B.C.</u> | | | | 29c. LICENSE NUMBER <u>D04383</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>5-9-90</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Lindsay RAE MFL Eastern Ave Balt Md.</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>MAY 14 1990</u> | | | | 32. REGISTRAR'S SIGNATURE <u>Jill Davidson-Randall</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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City

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Michael Jonathon Foster | | | | 2. DATE OF DEATH MONTH 5 DAY 10 YEAR 90 | | 3. TIME OF DEATH 7:10PM M | |
| 4. SOCIAL SECURITY NUMBER 216 96 9276 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 26 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan. 13 1964 | |
| 9a. FACILITY NAME (If not institution, give street and number) 210 Helena Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Essex | | 9c. COUNTY OF DEATH Baltimore County | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Essex | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 210 Helena Rd. | | | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16 or 17+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter | | 16b. KIND OF BUSINESS/INDUSTRY Construction | | | |
| 17. FATHER'S NAME (First, Middle, Last) John M. Foster, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Iris V. Elliott | | | |
| 19a. INFORMANT'S NAME (Type/Print) Bessie Baker, Sister | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 231 Dargun Dr. Apt. I Balto., Md. 21221 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Memorial Gardens | | 20c. LOCATION — City or Town, State Baltimore Co., Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home PA 1407 Old Eastern Ave. Balto., Md. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Contact shotgun wound of head DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 NO HEAD ONLY | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home XX Residence 5 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined XXX Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) FOUND: 5-10-90 | | 28b. TIME OF INJURY 5:00PM | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED Self inflicted | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) home | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-11-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mario F. Golle, Jr., MD 111 Penn Street, Baltimore, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) SHARON FRAZIER | | | | 2. DATE OF DEATH MONTH 5 DAY 9 YEAR 90 | | 3. TIME OF DEATH 10 M | |
| 4. SOCIAL SECURITY NUMBER 220-64-7335 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 33 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4/22/57 | |
| 8. FACILITY NAME (If not institution, give street and number) Seton Hill Nursing Home | | | | 9. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 10. COUNTY OF DEATH (city) | |
| 11. RESIDENCE OF DECEDENT | | | | 12. CITY, TOWN OR LOCATION | | 13. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 14. STATE MD | | | | 15. COUNTY Balto. | | 16. ZIP CODE 21206 | |
| 17. STREET AND NUMBER 5310 Eastbury Ave | | | | 18. CITIZEN OF WHAT COUNTRY? U.S.A | | 19. CITIZEN OF WHAT COUNTRY? | |
| 20. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 21. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 23. RACE — American Indian, Black, White, etc. Black | |
| 24. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 26. KIND OF BUSINESS/INDUSTRY | | 27. PLACE OF DEATH (Check only one) 1 <input checked="" type="checkbox"/> Hospital 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 28. FATHER'S NAME (First, Middle, Last) Walter Thompson | | | | 29. MOTHER'S NAME (First, Middle, Maiden Surname) Bernice Jackson | | | |
| 30. INFORMANT'S NAME (Type/Print) William Frazier | | | | 31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5310 Eastbury Ave 21206 | | | |
| 32. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 33. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmont Cemetery Baltimore, Md. | | 34. LOCATION — City or Town, State | |
| 35. SIGNATURE OF FUNERAL SERVICE LICENSEE James D. Hall | | | | 36. NAME AND ADDRESS OF FACILITY 1712-14 St. North Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → AIDS. | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. SMOKE (cerebral vascular accident) | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. NEURO-VASCULAR syphilis | | | | | | | |
| e. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Approximate Interval Between Onset and Death 2 years 2 months years? | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 26. PLACE OF DEATH (Check only one) at a chronic nursing facility | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) NA | | 28b. TIME OF INJURY NA | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED NA | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NA | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) NA | | 28g. DATE SIGNED (Month, Day, Year) 5/9/90 | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER David W. Oldach M.D. | | | | 29c. LICENSE NUMBER 301716591 | | 29d. DATE SIGNED (Month, Day, Year) 5/9/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) EFFIE L. GEORGE | | | | 2. DATE OF DEATH MONTH 05 DAY 07 YEAR 90 | | 3. TIME OF DEATH 10:20 P M | |
| 4. SOCIAL SECURITY NUMBER 177-07-1715 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-13-10 | |
| 8. BIRTHPLACE (State or Foreign Country) PENN. | | | | 9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MD. | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE, CITY | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3300 BENSON AVE. | |
| 10f. ZIP CODE 21227 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BOOKKEEPING | | 16b. KIND OF BUSINESS/INDUSTRY STORE | |
| 17. FATHER'S NAME (First, Middle, Last) Theron V. Lewis | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ISABELLE FINLAYSON | | | |
| 19a. INFORMANT'S NAME (Type/Print) JUDY MALIN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 NORTHWAY BALTIMORE, MD. 21218 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MT. CREMATORY | | 20c. LOCATION — City or Town, State BALTIMORE, MD. 21202 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edison M. Perkins</i> | | | | 22. NAME AND ADDRESS OF FACILITY 4905 YORK ROAD 21212 H.W. JENKINS AND SONS CO. BALTO, MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial Infarction Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Diffuse Disease | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Hilmer Negrete, M.D.</i> | | | | 29c. LICENSE NUMBER N/A | | 29d. DATE SIGNED (Month, Day, Year) 15/07/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HILMER NEGRETE, M.D. UNION MEMORIAL HOSPITAL BALTO, MD 21218 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-7146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH DARRELL GWYNN | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-8-90 | | 3. TIME OF DEATH 3:50AM M | |
| 4. SOCIAL SECURITY NUMBER 577-80-0885 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 32 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8 1 57 | |
| 9a. FACILITY NAME (If not institution, give street and number) Prince Georges General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cheverly | | 9c. COUNTY OF DEATH Prince Georges Co. | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Chapel Oaks | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1313 Nome Street | | | | 10f. ZIP CODE 20743 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Caterer | | 16b. KIND OF BUSINESS/INDUSTRY Private | | | |
| 17. FATHER'S NAME (First, Middle, Last) John D. Gwynn | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Yamada | | | |
| 19a. INFORMANT'S NAME (Type/Print) Louise Gwynn | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1313 Nome St/Chapel Oaks, Maryland 20743 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony | | 20c. LOCATION — City or Town, State Landover, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jimmy C. Neal, Sr. | | | | 22. NAME AND ADDRESS OF FACILITY J. B. Jenkins Funeral Home 7474 Landover Rd/Landover, Md 20785 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot wounds of chest and arm DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) FOUND: 5-8-90 | | 28b. TIME OF INJURY 3:33AM | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) front of ER | | 28e. DESCRIBE HOW INJURY OCCURRED Subject shot | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Maurice McKell | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-9-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) Margarita A. Korell, MD 111 Penn Street, Baltimore, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician to the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY V. HUGGINS | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 8:45 AM | |
| 4. SOCIAL SECURITY NUMBER 214-22-7744 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-5-1913 | |
| 9a. FACILITY NAME (If not institution, give street and number) Baltimore County General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown | | 9c. COUNTY OF DEATH Baltimore County | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Randallstown | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 3801 Schnaper Dr. Apt. 436 | | | | 10f. ZIP CODE 21133 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 years College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY --- | | | |
| 17. FATHER'S NAME (First, Middle, Last) DeForrest Terry | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Bartholomee | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. William R. Huggins Jr | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3801 Schnaper Dr. Apt 436 Randallstown, MD 21133 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Memorial Park | | 20c. LOCATION — City or Town, State Sykesville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE John K. Dy... | | | | 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIOGENIC SHOCK SEVERE CONGESTIVE CARDIOMYOPATHY Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DIABETES MELLITUS | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 6 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER John K. Dy... | | 29c. LICENSE NUMBER D19502 | | 29d. DATE SIGNED (Month, Day, Year) 5-11-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Orlando B. Conway MD BCCPH RANDALLSTOWN MD 21133 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNIVERSITY

of the State of New York

IN SENATE
January 11, 1906

REPORT

1906

1906

90 13146

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LARRY GLENN HILL | | | | 2. DATE OF DEATH MONTH 5 DAY 8 YEAR 90 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 219-58-4510 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 39 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/30/50 | |
| 9a. FACILITY NAME (If not institution, give street and number) 2615 Laurel Valley Garth | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Abington | | 9c. COUNTY OF DEATH Harford | |
| 10a. STATE Maryland | | 10b. COUNTY HARFORD | | 10c. CITY, TOWN OR LOCATION Abington | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2615 Laurel Valley Garth | | | | 10f. ZIP CODE 21009 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter | | 16b. KIND OF BUSINESS/INDUSTRY McCullough & Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Lester Hill | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Evelyn Hudson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Evelyn Hill | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 N. Rock Glen Road Apt. G Baltimore, MD 21229 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Crestlawn Garden of Memories | | 20c. LOCATION — City or Town, State Marriottsville, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kevin P. Smith</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carbon Monoxide Intoxication Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Inhalation of Auto Exhaust Fumes PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depression | | | | | | Approximate Interval Between Onset and Death 8-10 days | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Garage/Harford Co | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) est. 5/8/90 | | 28b. TIME OF INJURY unk. | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. Specify: Attached garage | | 28e. DESCRIBE HOW INJURY OCCURRED Inhaled auto exhaust | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2615 Laurel Valley Garth Abington | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. E. Smialek</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. E. SMIALEK, M.D., 111 Penn St., Balt. Md 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson Handell</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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90 13147

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Wiley Jones | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 5 1990 | | 3. TIME OF DEATH 5:45 AM | |
| 4. SOCIAL SECURITY NUMBER 219-05-1593A | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-10-1910 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE Maryland | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3916 Yolanda Rd | |
| 10f. ZIP CODE 21218 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) JUNIOUS Jones | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LENA Jones | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. LAUNIA WALLACE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3501 Fairview Ave. Apt. 6 Baltimore, Md. 21216 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cem. | | 20c. LOCATION — City or Town, State BALTO. Co. MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ | | | | 22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2226 W. North Ave. Baltimore, Md. 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Paralytic Meas | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Pneumonia | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Severe hypothyroidism | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure Dementia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO To be performed | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Sheave Gheorghiu M.D. | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/5/1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ILEANA GHEORGHIU, M.D. UNION MEMORIAL HOSPITAL. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE John Anderson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

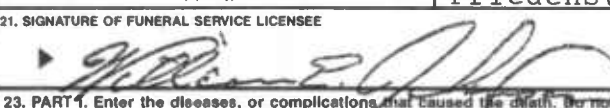
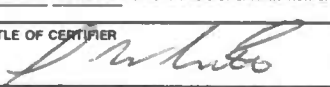
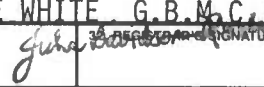
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BEATRICE W. JONES | | | | 2. DATE OF DEATH MONTH DAY YEAR 05-12-90 | | 3. TIME OF DEATH 12:23 AM | |
| 4. SOCIAL SECURITY NUMBER 133-26-5887-D | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05-29-1903 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Towson | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 302 E. Joppa Road #602 | |
| 10f. ZIP CODE 21204 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) ----- | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Home | |
| 17. FATHER'S NAME (First, Middle, Last) William P. Weidner | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Kline | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Malashek | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 E. Joppa Road #602 Towson, Maryland 21204 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Friedensville, Cemetery | | 20c. LOCATION — City or Town, State Upper Saucon, PA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY William E. Johnson, P.A. Funeral Home 8521 Loch Raven Blvd. Towson, MD 21204 | | | |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CHF Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>a. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>2ND TO M.I.</p> <p>b. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  DR. LAWRENCE WHITE | | | | 29c. LICENSE NUMBER D39258 | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. LAWRENCE WHITE, G.B.M.C., 6701 N. CHARLES STREET | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Laura M. Jackson | | | | 2. DATE OF DEATH MONTH 5 DAY 13 YEAR 90 | | 3. TIME OF DEATH 3:30A M | |
| 4. SOCIAL SECURITY NUMBER 212183756 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 68 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 0727921 | |
| 8a. FACILITY NAME (If not institution, give street and number) MERCY MEDICAL CENTER | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Baltimore, MD 21202 | | 8c. COUNTY OF DEATH Maryland | |
| 10a. STATE MD | | | | 10b. COUNTY — | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1521 E. CLEMENT ST. | | 10f. ZIP CODE 21230 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) — | |
| 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALES CLERK | | | | 16b. KIND OF BUSINESS/INDUSTRY — | | 17. FATHER'S NAME (First, Middle, Last) JOSEPH POLOMSKI | |
| 15. MOTHER'S NAME (First, Middle, Maiden Surname) CATHERINE BURDINSKI | | | | 18a. INFORMANT'S NAME (Type/Print) SANDRA GALLAGHER | | 18b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 DORCHESTER RD. CHEN BURNIE MD | |
| 19a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 19b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY ROSARY CEMETERY GERMAN HILL RD. | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE G. Huley Duda | | | | 22. NAME AND ADDRESS OF FACILITY Chapel of St. Stephen Burial Home 1591 E. Baltimore Ave. HMD | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Janette Friedman, MD | | 29c. LICENSE NUMBER pending | |
| 29d. DATE SIGNED (Month, Day, Year) 5/13/90 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Janette Friedman, M.D. Mercy Medical Center, Balb., MD 21202 | | 31. DATE FILED (Month, Day, Year) MAY 14 1990 | |
| 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | 33. DATE OF DEATH (Month, Day, Year) 5/13/90 | | 34. TIME OF DEATH 3:30A | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


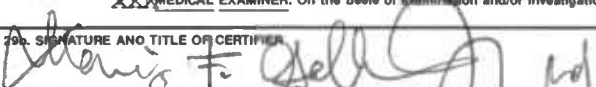
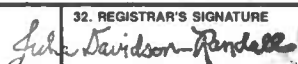
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Louis A. Jacob | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 2:47AM | |
| 4. SOCIAL SECURITY NUMBER 220-09-3997 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10/26/09 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1904 Wilhelm Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1904 Wilhelm Street | | | | 10f. ZIP CODE 21223 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Medical Technician | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Public Health Hosp. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Louis E. Jacob | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nanette M. Teufel | | | |
| 19a. INFORMANT'S NAME (Type/Print) Clara Brooks | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5760 Utrecht Road Rosedale, Md. 21206 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | 22. NAME AND ADDRESS OF FACILITY Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Multiple blunt force injuries and stab wounds to head and neck DUE TO (OR AS A CONSEQUENCE OF): Sequitely liit conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) FOUND: 5-11-90 | | 28b. TIME OF INJURY 2:33AM | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED Subject beaten and stabbed | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) home | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1904 Wilhelm Street, Baltimore City, Maryland | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  Mario F. Golle, Jr., MD | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-11-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Mario F. Golle, Jr., MD 111 Penn Street, Baltimore, MD 21201 vc | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11.11.03

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY KING | | | | 2. DATE OF DEATH MONTH 5 - DAY 9 - YEAR 90 | | | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 451-38-7652 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 5-17-1918 | |
| 9a. FACILITY NAME (If not institution, give street and number) 6 Shipley Ave. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE | | | | 9c. COUNTY OF DEATH St. Marys Co | |
| 10a. STATE Maryland | | | | 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 6 Shipley Ave. | | | | 10f. ZIP CODE 21228 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 6+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | 17. FATHER'S NAME (First, Middle, Last) Christopher Butler | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Carroll | | | | 19a. INFORMANT'S NAME (Type, Print) Mr. Murphy R. King | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 6 Shipley Ave. Catonsville, Md. 21228 | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Western Shore Cem. | | | | 20c. LOCATION — City or Town, State Catonsville, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ | | | | 22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2222 W. North Ave. Balt. Md 21216 | | | | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic colon cancer DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Paul Gormley | | | | 29c. LICENSE NUMBER D18587 | | | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL GORMLEY 900 Caton Ave S.H. MD 21229 | | | | 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

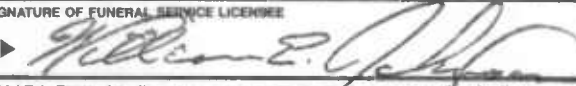
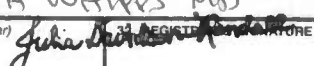
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES G. KELLY, SR. | | | | 2. DATE OF DEATH MONTH DAY YEAR May 10, 1990 | | 3. TIME OF DEATH 3:45 P.M. | |
| 4. SOCIAL SECURITY NUMBER 215-07-8674 | | 5. SEX XX M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8-28-1914 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. CITY, TOWN OR LOCATION OF DEATH 21212 | | 9c. COUNTY OF DEATH Baltimore Co. | |
| 9b. FACILITY NAME (If not institution, give street and number) 516 Castle Drive | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore Co. | |
| 10c. CITY, TOWN OR LOCATION 21212 | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 516 Castle Drive | |
| 10f. ZIP CODE 21212 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) 2 Years | | | |
| 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chief Admitting Officer Health Care | | | | 15b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) John I. Kelly | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Veronica Armstrong | | | |
| 19a. INFORMANT'S NAME (Type/Print) Kevin F. Kelly | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21214 2904 Gibbons Ave. Baltimore, Maryland | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Cemetery | | | |
| 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | |
| 22. NAME AND ADDRESS OF FACILITY William E. Johnson Funeral Home P.A. 8521 Loch Raven Blvd. Towson, MD 21204 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic cancer - colonie DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death 3 mos | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Randolph Whittes MD | | | | 29c. LICENSE NUMBER D22699 | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RANDOLPH WHITTES MD 201 EAST UNIVERSITY PARKWAY 21213 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 32. REGISTRAR'S SIGNATURE  | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20 12122

2001 12122

90 13153

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY E. LINDSAY | | | | 2. DATE OF DEATH MONTH 5 DAY 13 YEAR '90 | | 3. TIME OF DEATH 2:10 P.M. M | |
| 4. SOCIAL SECURITY NUMBER 220-24-1407 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05/26/1919 | |
| 9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Parkville | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1792 JOAN AVENUE | | | | 10f. ZIP CODE 21234 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 8+) 3 Years | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Registered Nurse | | 16b. KIND OF BUSINESS/INDUSTRY Medical - Hospital | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph F. Brown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anne A. Byrnes | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Ann Ford | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1409 Putty Hill Ave. Towson, Maryland 21204 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gar. | | 20c. LOCATION — City or Town, State Balto.Co., Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY William E. Johnson, P.A. Funeral Home 8521 Loch Raven Blvd. Towson, MD 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiac arrest</u> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. <u>Severe congestive heart failure</u> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. <u>Severe valvular disease</u> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. <u>Severe pulmonary disease</u> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D14754 | | 29d. DATE SIGNED (Month, Day, Year) 05.13.90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MAHMOOD ALI KHAN M.D., 7401 OSLER DRIVE, #212, BALTIMORE, MARYLAND 21204 | | | | | | | |
| 31a. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 31b. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8213: C:

ITEM:23 per DOCTOR
G-665 7-24-90 cm

90 13154

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) NICOLE ELIZABETH LATHAM | | | | 2. DATE OF DEATH MONTH 05 DAY 10 YEAR 90 | | 3. TIME OF DEATH 11:35 a m | | | | | | | |
| 4. SOCIAL SECURITY NUMBER N/A | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 1 05 | | 7. DATE OF BIRTH (Month, Day, Year) 5/10/90 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH BALTIMORE CITY | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore Highlands | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 2900 Florida Ave. | | | | 10f. ZIP CODE 21227 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) David E. Latham | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Karen A. Douglas | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) David E. Latham | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 Florida Ave. Baltimore, MD 21227 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery | | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jackie H. Shannon | | | | 22. NAME AND ADDRESS OF FACILITY Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>MECONIUM ASPIRATION</u> E-coli Septicemia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death 1 hour | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. — | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Margaret M. Moll, M.D. | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margaret M. Moll MD 600 N. WOLFE ST. BALTIMORE, MD. JOHNS HOPKINS HOSPITAL 21206 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR




TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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90 13155

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARGARET M. Limmer | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 7:22 A M | |
| 4. SOCIAL SECURITY NUMBER 214-20-4801 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 73 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 7-6-1916 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, Maryland | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 7508 Harford Rd. | | 10f. ZIP CODE 21234 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12th | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY Home | | 17. FATHER'S NAME (First, Middle, Last) Unknown | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | | | | 19a. INFORMANT'S NAME (Type/Print) Leo A. Limmer | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7508 Harford Rd. - Balto., Md. 21234 | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Cemetery | | 20c. LOCATION — City or Town, State Balto., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Hartley Miller Funeral Home 7527 Harford Rd. - Balto., Md. 21234 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Possible Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NOT APPLICABLE | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D23967 | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CESAR GALIBOR, MD 3440 BELAIR RD. BALTO MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

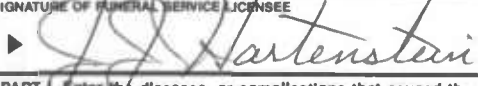
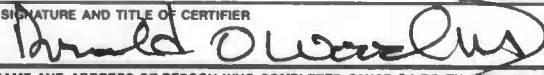
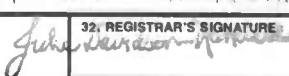
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13156

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Dallas Franklin Leith | | | | 2. DATE OF DEATH MONTH DAY YEAR May 9, 1990 | | 3. TIME OF DEATH 3:15 A M | |
| 4. SOCIAL SECURITY NUMBER 212-22-4414 | | 5. SEX 1 X M 2 F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Mar 27, 1908 | |
| 9a. FACILITY NAME (If not institution, give street and number) 3109 Monkton Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Monkton | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Monkton | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | |
| 10e. STREET AND NUMBER 3109 Monkton Road | | | | 10f. ZIP CODE 21111 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 X Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES W.W. II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Huntsman | | 16b. KIND OF BUSINESS/INDUSTRY Elkridge Harford Hunt Club | | | |
| 17. FATHER'S NAME (First, Middle, Last) Carroll Irvin Leith | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Estelle Furr | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Ellen Horner | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3109 Monkton Rd., Monkton, MD 21111 | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Yorkstone Cemetery Inc. cremation service | | 20c. LOCATION — City or Town, State York, PA | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Amyloidosis - primary DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF): Esophageal dyskenesia DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval between Onset and Death 9 years 1 week 1 week |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO |
| 27. MANNER OF DEATH 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D11174 | | 29d. DATE SIGNED (Month, Day, Year) 5/9/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donald O. Wood, M.D., 2 Greenmeadow Dr., Timonium, MD 21093 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 13122

90 13157

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Henrietta B. Linne | | | | 2. DATE OF DEATH MONTH 05 DAY 7 YEAR 1990 | | 3. TIME OF DEATH 950 P M | |
| 4. SOCIAL SECURITY NUMBER 215-01-5816 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6-27-1912 | |
| 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Med. Ctr. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Md. Maryland | |
| 10a. STATE Md. | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Dundalk | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 7612 Spruce Rd. Dundalk | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School College (1-4 or 5+) 3 yrs | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Asst. Librarian | | 16b. KIND OF BUSINESS/INDUSTRY Pratt Library | | | |
| 17. FATHER'S NAME (First, Middle, Last) Lloyd Tilghman Boyce | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Etta Comegys | | | |
| 19a. INFORMANT'S NAME (Type/Print) Milton A. Linne | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7612 Spruce Rd. Dundalk, MD. 21222 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Memorial Gardens Balto., Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, INC. 2134 Willow Spring Rd. Dundalk, MD. 21222 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Med. Resident | | | | 29c. LICENSE NUMBER 039102 | | 29d. DATE SIGNED (Month, Day, Year) 5/7/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | | | | |
| 32. REGISTRAR'S SIGNATURE | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 13121

90 13158

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEASED (First, Middle, Last) Nellie B. Leland | | | | 2. DATE OF DEATH MONTH 5 DAY 9 YEAR 90 | | 3. TIME OF DEATH 5:45 A.M. | |
| 4. SOCIAL SECURITY NUMBER 220-44-4159 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 99 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11/24/1890 | |
| 8a. FACILITY NAME (If not institution, give street and number) Manor Care/Ruxton | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 8c. COUNTY OF DEATH Baltimore | |
| 10a. STATE MD | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3201 32nd Street | | | |
| 10f. ZIP CODE 21218 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker | | 16b. KIND OF BUSINESS/INDUSTRY own home | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Peterson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Fales | | | |
| 19a. INFORMANT'S NAME (Type/Print) Jane L. Rupprecht | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Yarmouth Road/Balto. MD 21204 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Crematory | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Peter Sleator</i> | | | | 22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd/Balto. MD 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Probably cardiac arrest. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>William G. Pann</i> M.D. | | | | 29c. LICENSE NUMBER 002966 | | 29d. DATE SIGNED (Month, Day, Year) 5/9/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Rendell</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 18128

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13159

| | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Gerard E. Morgan</u> (GERARD E. MORGAN) | | | | 2. DATE OF DEATH MONTH DAY YEAR <u>5</u> <u>12</u> <u>90</u> | | 3. TIME OF DEATH <u>9⁴⁰</u> A M | | | | |
| 4. SOCIAL SECURITY NUMBER <u>215 16 1085</u> | | 5. SEX <u>1</u> M <u>2</u> F | | 8. AGE (In yrs. last birthday) <u>72</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>2-15-18</u> | | 8. BIRTHPLACE (State or Foreign Country) <u>MD.</u> | | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Loch Raven Veterans Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Balt. MD</u> | | | 9c. COUNTY OF DEATH <u>Balt.</u> | | | |
| 10a. STATE <u>MD.</u> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <u>BALTIMORE, CITY</u> | | | 10d. INSIDE CITY LIMITS? <u>XX</u> YES <u>2</u> NO | | | |
| 10e. STREET AND NUMBER <u>407 PARK AVE.</u> | | | | 10f. ZIP CODE <u>21201</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | |
| 11. MARITAL STATUS <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <u>1</u> YES <u>2</u> NO IF YES, GIVE WAR OR DATES <u>WW II</u> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> YES <u>2</u> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White.</u> | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10</u> College (1-4 or 5+) <u>College</u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>MAIL ROOM</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>POST OFFICE</u> | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>GERARD MORGAN</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>AMY COCHRAN</u> | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>FRANCIS V. MORGAN</u> | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2918 N. CALVERT ST. BALTIMORE, MD. 21218</u> | | | | | | | | |
| 20a. METHOD OF DISPOSITION <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>BALTIMORE NATIONAL</u> | | 20c. LOCATION — City or Town, State <u>BALTIMORE, MD 21228</u> | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Edison M. Perkins</u> | | 22. NAME AND ADDRESS OF FACILITY <u>4905 YORK ROAD 21212</u> <u>H.W. JENKINS AND SONS CO. BALTO. MD</u> | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Respiratory Arrest.</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <u>Squamous Cell Ca of Oropharynx.</u> DUE TO (OR AS A CONSEQUENCE OF): <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death <u>Immediate</u> <u>3 days</u> | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <u>1</u> YES <u>2</u> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <u>1</u> YES <u>2</u> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <u>1</u> YES <u>2</u> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA OTHER: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH <u>1</u> Natural <u>5</u> Pending Investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <u>1</u> YES <u>2</u> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. CERTIFIER (Check only one) <u>1</u> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Delia A. Becker</u> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <u>5-12-90</u> | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Loch Raven VA Hospital 3900 Loch Raven Blvd Balt MD 21215</u> | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>MAY 14 1990</u> | | 32. REGISTRAR'S SIGNATURE <u>John Davidson-Hendell</u> | | | | | | | | |

Abstract of the Report

90 13160

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Jannie McCants | | | | 2. DATE OF DEATH MONTH DAY YEAR May 11, 1990 | | 3. TIME OF DEATH 5:45 A M | |
| 4. SOCIAL SECURITY NUMBER 248 58 5473 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 52 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) SEPTEMBER 16, 1937 | |
| 9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10e. STREET AND NUMBER 3112 SUMTER AVENUE | | 10f. ZIP CODE 21215 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S. OF A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY HOMEMAKER | |
| 17. FATHER'S NAME (First, Middle, Last) DAN MOBLEY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MILDRED HARRIS | | | |
| 19a. INFORMANT'S NAME (Type/Print) MR. ALVIN MC CANTS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 SUMTER AVENUE BALTIMORE, MARYLAND 21215 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY 5/14/90 | | 20c. LOCATION — City or Town, State BALTO. CATONSVILLE, MD. CO. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lewis T. Gwynn</i> | | | | 22. NAME AND ADDRESS OF FACILITY LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVE. BALTIMORE, MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Malignant Cardiac Arrhythmia | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Arthur Vayer M.D.</i> | | | | 29c. LICENSE NUMBER N/A | | 29d. DATE SIGNED (Month, Day, Year) 5-11-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Arthur Vayer M.D. c/o Maryland General Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John H. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13161

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|--|---------------------------------|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Doris V McGregor | | 2. DATE OF DEATH MONTH 5 DAY 12 YEAR 90 | | 3. TIME OF DEATH 1446 P.M. |
| 4. SOCIAL SECURITY NUMBER 217-3A-8778 | 5. SEX 1 M 2 F | 6. AGE (In yrs. last birthday) 66 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 09-29-23 | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number) Balto. Co. Gen. Hosp | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown, Md | | 9c. COUNTY OF DEATH Balto Co. |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore County | | 10c. CITY, TOWN OR LOCATION Baltimore |
| 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | 10e. STREET AND NUMBER 8013 Douglas Ave. | | |
| 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th grade College (1-4 or 5+) Unemployed | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unemployed | | 16b. KIND OF BUSINESS/INDUSTRY | | |
| 17. FATHER'S NAME (First, Middle, Last) Arthur Franklin Pease | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth Kuehn | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Marvin Younkers | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8013 Douglas Ave. Baltimore, MD 21207 | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Wards Chapel Church Cemetery | | 20c. LOCATION — City or Town, State Randallstown, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE John K. Agnew | | 22. NAME AND ADDRESS OF FACILITY 8728 Liberty Rd. Randallstown, MD 21133 Loring Byers Funeral Directors, Inc. | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Breast Carcinoma Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 26. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 7 Homicide | | 27. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Gregory S. Gordon | | 29c. LICENSE NUMBER D39469 | | 29d. DATE SIGNED (Month, Day, Year) 5-12-90 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Baltimore County Gen. Hosp. | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital and the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for filing within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13162

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ANNIE THOMAS MILLER | | | | 2. DATE OF DEATH MONTH DAY YEAR 05-13-1990 | | 3. TIME OF DEATH 1:30 A.M. | |
| 4. SOCIAL SECURITY NUMBER 220-24-5435 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 16, 1896 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3612 Clifton Avenue | |
| 10f. ZIP CODE 21216 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Insurance | | 16b. KIND OF BUSINESS/INDUSTRY Southern Life | |
| 17. FATHER'S NAME (First, Middle, Last) William Frisby Thomas | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Lee | | | |
| 19a. INFORMANT'S NAME (Type/Print) Charles T. Miller | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 North Carrollton Ave. Baltimore, MD 21217 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore National Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gary L. Rollins | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MULTIORGAN SYSTEM FAILURE DUE TO (OR AS A CONSEQUENCE OF): SEPSIS Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): 9A MULTIPLE OPERATIVE PROCEDURES DUE TO (OR AS A CONSEQUENCE OF): SMALL BOWEL GANGLIONOUS OBSTRUCTION CHOLELITHS | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ADULT RESPIRATORY DISTRESS SYNDROME | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Eric E. Jones, M.D. | | | | 29c. LICENSE NUMBER D31300 | | 29d. DATE SIGNED (Month, Day, Year) 5/13/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ERIC E. JONES, M.D. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE J. H. Davidson | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Joseph W. <i>Maloney</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>May 5 1990</i> | | 3. TIME OF DEATH M <i>1847</i> | |
| 4. SOCIAL SECURITY NUMBER <i>221-01-8737</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) YRS. <i>73</i> | | 7. DATE OF BIRTH (Month, Day, Year) <i>9/13/16</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) Peninsula General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Salisbury, MD | | 9c. COUNTY OF DEATH Wicomico | |
| 10a. STATE Del. | | | | 10b. COUNTY Sussex | | 10c. CITY, TOWN OR LOCATION Milford | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 19 Dot St. | | | |
| 10f. ZIP CODE 19963 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WWII</i> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>2</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Civil Engineer</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Civil Service</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) Patrick Maloney | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rhadie Ennis | | | |
| 19a. INFORMANT'S NAME (Type/Print) Florence C. Maloney | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Dot St. Milford, Del. 19963 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Odd Fellows Cemetery</i> | | 20c. LOCATION — City or Town, State <i>Milford, Del.</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dwight C. Bruns</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Boards F.H. Salisbury Md.</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Renal Failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Benjamin H. Meyers</i> | | | | 29c. LICENSE NUMBER <i>D30743</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>5/6/90</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>BENJAMIN H MEYERS, M.D. Quincey + Locust SALISBURY, MD 21801</i> | | | | | | | |
| 31. DATE FILLED (Month, Day, Year) <i>MAY 14 1990</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 12:22

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lela Bell Miller | | | | | | | | 2. DATE OF DEATH May 7, 1990 | | | | 3. TIME OF DEATH M | | | |
| 4. SOCIAL SECURITY NUMBER 216 20 6690 | | | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 20, 1911 | | 8. BIRTHPLACE (State or Foreign Country) Fairview, Mo. | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 1420 Kent Road | | | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Essex | | | | 9c. COUNTY OF DEATH Baltimore Co. | | | |
| 10a. STATE Maryland | | | | | | | | 10b. COUNTY Baltimore | | | | 10c. CITY, TOWN OR LOCATION Essex | | | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | 10e. STREET AND NUMBER 1420 Kent Road | | | | 10f. ZIP CODE 21221 | | | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | | | | | | | 16b. KIND OF BUSINESS/INDUSTRY Home | | | | 17. FATHER'S NAME (First, Middle, Last) Stella Oster | | | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Maude Blynn | | | | | | | | 19a. INFORMANT'S NAME (Type/Print) Stephen A. Miller, Husband | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1420 Kent Rd. Balto., Md. 21221 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Memorial Gardens | | | | 20c. LOCATION — City or Town, State Baltimore Co., Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John J. Bruzdinski</i> | | | | | | | | 22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home PA 1407 Old Eastern Ave. Balto., Md. 21221 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Candidiasis failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Metastatic Recurrent Carcinoma of colon</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Advanced carcinoma of Rectosigmoid colon</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Apparao N. V. Varghese M.D.</i> | | | | | | | | 29c. LICENSE NUMBER D 19691 | | | | 29d. DATE SIGNED (Month, Day, Year) 5/8/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) APPARAO N. V. VARGHESE, M.D., 900 S. ELLWOOD AVE, BALTIMORE Md. 21224 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | | | | | 32. REGISTRAR'S SIGNATURE <i>Sylvia Davidson-Randall</i> | | | | | | | |

DO 12121

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13165

| | | | | | | | | | |
|--|--|---|--|--|--|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MICHAEL MICKEL | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 11 1990 | | 3. TIME OF DEATH 9:00AM M | | | |
| 4. SOCIAL SECURITY NUMBER 177-09-3797 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) OCT. 14, 1907 | | 8. BIRTHPLACE (State or Foreign Country) Virginia | |
| 9a. FACILITY NAME (If not institution, give street and number) 12324 CLAYDENT LANE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH KINGSVILLE | | | 9c. COUNTY OF DEATH BALTIMORE | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION KINGSVILLE | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 12324 CLAYDENT LANE | | | | 10f. ZIP CODE 21087 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: X | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SHEET METAL WORKER | | 16b. KIND OF BUSINESS/INDUSTRY MARTIN MARRIETTA CORP. | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN MICKEL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) JULIA KVOCKA | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARY MICKEL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12324 CLAYDENT LANE KINGSVILLE, MD. 21087 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY TRINITY CHURCH CEMETERY | | 20c. LOCATION — City or Town, State ELKRIDGE, MARYLAND | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Martin J. Dippel</i> | | | | 22. NAME AND ADDRESS OF FACILITY DIPPEL FUNERAL HOME, INC. 7110 BELAIR ROAD BALTIMORE, MD. 21206 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Carcinoma Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Colon Cancer originally b. Due to (OR AS A CONSEQUENCE OF): c. Due to (OR AS A CONSEQUENCE OF): d. Due to (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death 18 mos. 72 yrs | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis Liver Failure Metastatic | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregory Bulkey</i> DR. GREGORY BULKEY | | 29c. LICENSE NUMBER D15746 | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. GREGORY BULKEY 600 N. WOLFE STREET BALTIMORE, MD. 21205 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | | | | | | |

50 15103

90 13166

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Evelyn C. OAKES | | | | 2. DATE OF DEATH MONTH 5 DAY 13 YEAR 90 | | 3. TIME OF DEATH 6:15 a.m. | |
| 4. SOCIAL SECURITY NUMBER 225 01 8038 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 1 1920 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) Franklin Sq. Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | |
| 9c. COUNTY OF DEATH Baltimore County | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Essex | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 42 Pelczar Ave. | |
| 10f. ZIP CODE 21221 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | | | 16b. KIND OF BUSINESS/INDUSTRY Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Walter W. Mason | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Carwile | | | |
| 19a. INFORMANT'S NAME (Type/Print) Theresa Munez, Daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42 Pelczar Ave. Balto., Md. 21221 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cemetery | | | |
| 20c. LOCATION — City or Town, State Baltimore Co., Md. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | |
| 22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home PA 1407 Old Eastern Ave. Balto., Md. 21221 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Cardiovascular Disease Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Cardiopulmonary Arrest c. d. Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other (Specify) | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D37242 | | | |
| 29d. DATE SIGNED (Month, Day, Year) 5/13/90 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Paul Hagen, M.D. 9000 Franklin Square Drive Baltimore 21237 | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 10100

90 13167

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ANTHONY M. ROANE | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 9, 1990 | | 3. TIME OF DEATH 6:10 p.m. | |
| 4. SOCIAL SECURITY NUMBER 212-76-3982 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 32 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 01-04-58 | |
| 8. BIRTHPLACE (State or Foreign Country) BALTO. | | | | 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH BALTIMORE CITY | | | | 10a. STATE MD | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE, CITY | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2615 E. BIDDLE STREET | |
| 10f. ZIP CODE 21213 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th GRADE College (1-4 or 5+) 2 yrs. | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY WEBER TRUCKING CO. | |
| 17. FATHER'S NAME (First, Middle, Last) RALPH ROANE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CAROLYN COPPER | | | |
| 19a. INFORMANT'S NAME (Type/Print) CAROLYN ROANE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2615 E. BIDDLE ST. BALTIMORE, MD. 21213 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladys Waver | | | | 22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H.-1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiogenic shock / Debat. Cardiomyopathy</u> Approximate Interval Between Onset and Death 2 d | | | | | | | |
| b. <u>Sepsis</u> 2 d | | | | | | | |
| c. <u>Renal failure</u> 1 d | | | | | | | |
| d. <u>Liver failure</u> 1 d | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER David W. Allen MD | | | | 29c. LICENSE NUMBER E9814 | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David W. Allen, MD Johns Hopkins Hosp. Baltimore, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

no 13167

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 90 13168 | | | | | |
|---|--|--|--|--|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | | | |
| 1. DECEASED'S NAME (First, Middle, Last) KATHRYN GREEN REMINGTON | | | | 2. DATE OF DEATH MONTH DAY YEAR 5- 11-1990 | | | | 3. TIME OF DEATH 3:10 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 215-24-0478 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5- 1-1913 | | 8. BIRTHPLACE (State or Foreign Country) MD. | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) MANOR CARE RUXTON | | | | 9b. CITY, TOWN OR LOCATION OF DEATH RUXTON | | | | 9c. COUNTY OF DEATH BALTIMORE | | | | | |
| 10a. STATE MD. | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 6009 HUNT RIDGE ROAD | | | | 10f. ZIP CODE 21210 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 8+) | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSE WIFE | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLES F. GREEN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY DAUGHERTY | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) JOHN C. REMINGTON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1842 LOCH SHIEL ROAD, BALTIMORE, MD. 21234 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) NEW CATHEDRAL CEM. | | 20c. LOCATION — City or Town, State BALTIMORE, MD. 21209 | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edison M. Restina</i> | | | | 22. NAME AND ADDRESS OF FACILITY 4905 YORK ROAD 21212 H.W. JENKINS AND SONS CO. BALTO. MD. | | | | | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Adenocarcinoma of the Lung</i> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Emphysema, Hypertension, ASCVD, & Atrial Fibrillation</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD | | 29c. LICENSE NUMBER D53897 | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT J. VISSING 4300 NORTH CHARLES ST. BALTO. MD | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Juba Davidson-Rendell</i> | | | | | | | | | |

01/01/01 01

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13169

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Helen D. Reynolds | | | | 2. DATE OF DEATH MONTH 5 DAY 5 YEAR 90 | | 3. TIME OF DEATH 7 14 A M | | | |
| 4. SOCIAL SECURITY NUMBER 168-12-2942 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12/27/1908 | | 8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA | |
| 9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Harre de Grace | | | | 9c. COUNTY OF DEATH Harford | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY HARFORD | | 10c. CITY, TOWN OR LOCATION DARLINGTON | | | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2512 SHURESVILLE ROAD | | | | 10f. ZIP CODE 21034 | |
| 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) HOMEMAKER | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWN HOME | | | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | | 17. FATHER'S NAME (First, Middle, Last) UNKNOWN | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN | | | | 19a. INFORMANT'S NAME (Type/Print) ELIZABETH S. KEEFER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2706 FAWKES DRIVE WILMINGTON, DE 19808 | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) DARLINGTON CEMETERY | | | | 20c. LOCATION — City or Town, State DARLINGTON, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeffrey P. Lovelace | | | | 22. NAME AND ADDRESS OF FACILITY HARKINS FUNERAL HOME, INC, DELTA, PA | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ① Acute Pulmonary Edema & Cardiac 1 week DUE TO (OR AS A CONSEQUENCE OF): Arrest, resuscitated & Cerebral anoxia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST ② Acute Anteroseptal Myocardial 1 week DUE TO (OR AS A CONSEQUENCE OF): infarction & Coronary Heart Disease | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. = Lower respiratory tract infection = Septic shock = Diabetes mellitus | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER 205676 | | 29d. DATE SIGNED (Month, Day, Year) 5/5/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EC. Loo, M.D., 319 S. Union Ave., Harre de Grace, Md 21088 | | | | 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lincoln O. Rawlings | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-9-90 | | 3. TIME OF DEATH 10:25AM M | |
| 4. SOCIAL SECURITY NUMBER 216-05-3416 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/10/1915 | |
| 8. BIRTHPLACE (State or Foreign Country) Md | | | | 9a. FACILITY NAME (If not institution, give street and number) 3403 Glen Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH Baltimore City | | | | 10a. STATE Md | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION Baltimore City | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3403 Glen Ave | |
| 10f. ZIP CODE 21215 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Beverly M. M. Has | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3403 Glen Ave - Baltimore, Md. 21215 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Vernon Cemetery | | 20c. LOCATION — City or Town, State Garrison, Maryland, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | | | 22. NAME AND ADDRESS OF FACILITY Garrison Funeral Home 1712-14 W. North Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO INQUIRY | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-9-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita A. Korell, MD 21201 111 Penn Street, Baltimore, MD 21201 vc | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13171

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|--|--|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) GARY SMITH | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 10 90 | | 3. TIME OF DEATH 4:56 AM | | |
| 4. SOCIAL SECURITY NUMBER 214-62-7511 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 35 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10/2/54 | | |
| 8a. FACILITY NAME (If not institution, give street and number) ST. JOSEPH HOSPITAL | | | | 8b. CITY, TOWN OR LOCATION OF DEATH TOWSON, MD. | | 8c. COUNTY OF DEATH BALTIMORE | | |
| 9. RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | | |
| 10a. STATE MD | | 10b. COUNTY | | BALTIMORE, CITY | | <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 4001 W. NORTHERN PKWY. APT. B-1 | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3YRS | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY U.S.F. & G. | | | | |
| 17. FATHER'S NAME (First, Middle, Last) CLIFTON SMITH SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) RUTH BENTLEY | | | | |
| 19a. INFORMANT'S NAME (Type/Print) SYLVIA G. SMITH | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4001 W. NORTHERN PKWY APT B-1 BALTO, MD. 21215 | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA. | | 20c. LOCATION — City or Town, State OWINGS MILLS | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladys Wanner | | | | 22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H. 1101 E. NORTH AVE. | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CRYPTOCOCCAL MENINGITIS DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. ACQUIRED IMMUNODEFICIENCY SYNDROME DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Bladys Wanner | | | | 29c. LICENSE NUMBER D33215 | | 29d. DATE SIGNED (Month, Day, Year) 05/10/90 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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17121 00

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) Grace Stewart | | | | 2. DATE OF DEATH MONTH 5 DAY 09 YEAR 90 | | 3. TIME OF DEATH 0509 A. M | |
| 4. SOCIAL SECURITY NUMBER 212-32-1723 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 81 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 2/25/09 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) St Agnes Hosp. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 815 Winters Lane | | | | 10f. ZIP CODE 21228 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Ernest Jackson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Holland | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Evelyn White | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1007 Park Valley Baltimore, Md. 21208 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore Nat Cem | | 20c. LOCATION — City or Town, State Baltimore, Co. Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph J. Russ | | | | 22. NAME AND ADDRESS OF FACILITY Joseph J. Russ Funeral Home 2222 W. North Ave. Baltimore, Md. 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 hr. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): 2 yrs. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER David R. Moseman, M.D. Attending | | | | 29c. LICENSE NUMBER D1987L | | 29d. DATE SIGNED (Month, Day, Year) 5-9-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Moseman, M.D. 5205 East Dr. Arbutus, Md 21227 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13173

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)

Harritte Spince

2. DATE OF DEATH
MONTH 05 DAY 11 YEAR 90

3. TIME OF DEATH 4:05 AM

4. SOCIAL SECURITY NUMBER

217-68-2399

5. SEX

1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday)

78 YRS.

IF UNDER 1 YEAR

MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.

HOURS MIN.

7. DATE OF BIRTH

(Month, Day, Year)
2/23/12

8. BIRTHPLACE (State or Foreign Country)

Maryland

9a. FACILITY NAME (If not institution, give street and number)

CHURCH HOSPITAL CORPORATION

9b. CITY, TOWN OR LOCATION OF DEATH

BALTIMORE CITY

9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE

MD.

10b. COUNTY

10c. CITY, TOWN OR LOCATION

BALTIMORE CITY

10d. INSIDE CITY LIMITS?

1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER

1610 E. FEDERAL ST.

10f. ZIP CODE

21213

10g. CITIZEN OF WHAT COUNTRY?

USA

11. MARITAL STATUS

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:14. RACE — American Indian, Black, White, etc.
Specify:
Black

15. DECEDENT'S EDUCATION

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. DECEDENT'S USUAL OCCUPATION

(Give kind of work done during most of working life. Do NOT use retired.)

Domestic

16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last)

William Gordon

18. MOTHER'S NAME (First, Middle, Maiden Surname)

Martha Ann N/A

19a. INFORMANT'S NAME (Type/Print)

James Taylor

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1610 E. Federal St. Balto., Md. 21213

20a. METHOD OF DISPOSITION

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)

Balto. Cemetery

20c. LOCATION — City or Town, State

Balto City, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE

Carlton C. Douglass

22. NAME AND ADDRESS OF FACILITY

DOUGLASS FUNERAL SERVICE

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

CARDIO-RESPIRATORY FAILURE

Approximate Interval Between Onset and Death

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. Cardio-Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF) METASTATIC BREAST CANCERb. Metastatic Breast Cancer
DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?

1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)

HOSPITAL:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

OTHER:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. DATE OF INJURY

(Month, Day, Year)

28b. TIME OF INJURY

M

28c. INJURY AT WORK?

1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURRED

28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER

(Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

Sabah Al-Attar, MD

29c. LICENSE NUMBER

D37725

29d. DATE SIGNED (Month, Day, Year)

05/11/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Sabah Al-Attar, Church Hosp., Baltimore, Md.

31. DATE FILED (Month, Day, Year)

MAY 14 1990

32. REGISTRAR'S SIGNATURE

John Davidson-Randall

CHURCH HOSPITAL

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) FRANCIS H. STEWART | | | | 2. DATE OF DEATH MONTH MAY DAY 10 YEAR 1990 | | 3. TIME OF DEATH 10 A M | |
| 4. SOCIAL SECURITY NUMBER 172-05-5295 | | 5. SEX XX M <input type="checkbox"/> F <input type="checkbox"/> | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7/14/05 | |
| 8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA | | | | 9a. FACILITY NAME (If not institution, give street and number) 1518 DOOLEY ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH WHITEFORD | |
| 9c. COUNTY OF DEATH HARFORD | | | | 10a. STATE MD | | 10b. COUNTY HARFORD | |
| 10c. CITY, TOWN OR LOCATION WHITEFORD | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 1518 DOOLEY ROAD | |
| 10f. ZIP CODE 21160 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HEAVY EQUIP. OPERATOR | | 16b. KIND OF BUSINESS/INDUSTRY QUARRY | |
| 17. FATHER'S NAME (First, Middle, Last) FRANKLIN J. STEWART | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CATHERINE BROWNSBURGER | | | |
| 19a. INFORMANT'S NAME (Type/Print) C. REGINA STEWART | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1518 DOOLEY RD., WHITEFORD, MD., 21160 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ST. MARY'S CEMETERY | | 20c. LOCATION — City or Town, State PYLESVILLE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jeffrey P. Lovelidge</i> | | | | 22. NAME AND ADDRESS OF FACILITY HARKINS F.H. INC., 600 MAIN ST., DELTA, PA. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → - Metastatic Merkel Cell Cancer DUE TO (OR AS A CONSEQUENCE OF): b. - Metastatic Prostate Cancer DUE TO (OR AS A CONSEQUENCE OF): c. - Renal Failure (2° to Above). DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>J.M. Lynch</i> | | | | 29c. LICENSE NUMBER D35012 | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KEVIN J. LYNCH, M.D., BOULTON ST., BEL AIR, MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Gordon-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) NOAH SAMUEL SHOCKEY | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 07 90 | | 3. TIME OF DEATH 06:30 A M | |
| 4. SOCIAL SECURITY NUMBER 234-26-9589 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 5, 1917 | |
| 9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | | 9c. COUNTY OF DEATH ALLEGANY | |
| 10a. STATE WV | | | | 10b. COUNTY Mineral | | 10c. CITY, TOWN OR LOCATION Keyser | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 51 Front Street | | | | 10f. ZIP CODE 26726 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction Worker | | 16b. KIND OF BUSINESS/INDUSTRY Industrial | | | |
| 17. FATHER'S NAME (First, Middle, Last) Alfred Thomas Shocke | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Julia Frances Smith | | | |
| 19a. INFORMANT'S NAME (Type/Print) Doris Helsley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Star Rt 1 Box 8 Keyser, WV 26726 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Duling Cemetery | | 20c. LOCATION — City or Town, State Keyser, WV 26726 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Rotruck Funeral Home 85 S. Main St Keyser, WV 26726 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary arrest</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Severe ischemic cardiomyopathy</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Acute renal failure, Sepsis, Prostatic Cancer with liver mets</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute renal failure, Sepsis, Prostatic Cancer with liver mets</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Orolino</i> | | | | 29c. LICENSE NUMBER D34846 | | 29d. DATE SIGNED (Month, Day, Year) 5/7/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. ROBERT ORLINO, M.D., 900 SETON DRIVE, CUMBERLAND, MARYLAND 21502 | | | | | | | |
| 31. DATE (Month, Day, Year) MAY 14 1990 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21101 EC

90 13176

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) VERNON SEYMORE | | | | 2. DATE OF DEATH MONTH DAY YEAR 05/07/1990 | | 3. TIME OF DEATH 11:35 P.M. | |
| 4. SOCIAL SECURITY NUMBER 212-05-9364 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7-19-11 | |
| 8a. FACILITY NAME (If not institution, give street and number) HOMEWOOD HOSPITAL CENTER | | | | 8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 8c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 11 W. 20th Street | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Vanessa Hicks | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 W. 20th St Balb, Md. 21218 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Md Va. | | 20c. LOCATION — City or Town, State Owings Mill, Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven Carroll | | | | 22. NAME AND ADDRESS OF FACILITY IRVIN CARROLL Funeral Home 1712 W. North Ave, Balb, Md. 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → - RENAL FAILURE | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): Neoplasm of kidney | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 28. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER J. Ansari MD | | | | 29c. LICENSE NUMBER D16934 | | 29d. DATE SIGNED (Month, Day, Year) 5/7/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Ansari, HOME WOOD SOUTH HOSPITAL, BALTIMORE, MD. 21218 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE Gabe Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13177

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIE THOMAS (WILLIE M. THOMAS) | | | | 2. DATE OF DEATH MONTH 5 DAY 9 YEAR 90 | | 3. TIME OF DEATH 15:35 P M | |
| 4. SOCIAL SECURITY NUMBER 216-12-3662 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 09/03/21 | |
| 9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, MARYLAND | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, CITY | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 10e. STREET AND NUMBER 2571 CECIL AVE | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 3rd GRADE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY SPARROWS POINT | | | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLIE THOMAS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) FLORENCE HASKIN | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. FLORA THOMAS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2571 CECIL AVE. BALTO, MD. 21218 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST CEMETERY | | 20c. LOCATION — City or Town, State OWINGS MILLS | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladys Wanner | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIOPULMONARY FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. DISEMINATED INTRAVASCULAR COAGULATION DUE TO (OR AS A CONSEQUENCE OF): c. CHRONIC MYELOIDIC LEUKEMIA BLAST CRISIS DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANEMIA, GASTRIC EROSION, HYPERTENSION, GOUT MEINGEAL LEUKEMIA INFILTRATION | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Thomson Nguyen MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/9/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NGUYEN, VINCENT MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | 32. REGISTRAR'S SIGNATURE Erica K. Boudell | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 13177

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES THOMPSON | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 11:03 P M | |
| 4. SOCIAL SECURITY NUMBER 258-58-0680 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 49 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-10-40 | |
| 9a. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Clinton | | 9c. COUNTY OF DEATH Prince George's | |
| 10a. STATE GA. | | | | 10b. COUNTY FULTON CO. | | 10c. CITY, TOWN OR LOCATION COLLEGE PARK | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2843 OLD FARM RD. | | | |
| 10f. ZIP CODE 30349 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERK | | 16b. KIND OF BUSINESS/INDUSTRY GENERAL MOTORS | | | |
| 17. FATHER'S NAME (First, Middle, Last) LEWIS THOMPSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ARLENA WILLIS | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARCHE THOMPSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 343 SIMPSON TERR. SW. ATLANTA, GA. 30314 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) WESTVIEW CEMETERY | | 20c. LOCATION — City or Town, State ATLANTA GA. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Bladys Warren</i> | | | | 22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 5-11-90 | | 28b. TIME OF INJURY 9:48 P M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED Passenger of auto/auto impact | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) roadway | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Rt. 5 at Coventry Way, Clinton, P.G. County, MD | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Walter D. Hall</i> | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-12-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita A. Korell, M.D., Assistant 111 Penn Street, Baltimore, MD 21201 vl | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECTION 62

90 13179

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) FANNIE TERRY | | | | 2. DATE OF DEATH MONTH DAY YEAR 3-8-90 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER NONE | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 99 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-15-90 | |
| 9a. FACILITY NAME (If not Institution, give street and number) Constance Care | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3020 Wayne Ave | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Morton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sally Morton | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Charles Bagley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1913 McKenn Ave. Balto. Md. | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Cem | | 20c. LOCATION — City or Town, State Balto. Co. Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ | | | | 22. NAME AND ADDRESS OF FACILITY Joseph A. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary artery disease Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): Decubiti ulcer c. DUE TO (OR AS A CONSEQUENCE OF): Cardio pulmonary arrest d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER D30115 | | 29d. DATE SIGNED (Month, Day, Year) 5/9/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T. Ohiokepe, MD 2800 Liberty Hts Ave Balto MD 21215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 12

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Vida E. Tennant | | | | 2. DATE OF DEATH MONTH DAY YEAR May 11 1990 | | 3. TIME OF DEATH 4:30 A^M | |
| 4. SOCIAL SECURITY NUMBER 109-42-5743 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 15, 1911 | |
| 8. BIRTHPLACE (State or Foreign Country) Jamaica | | | | 9. FACILITY NAME (If not institution, give street and number) Leland Memorial Hospital | | | |
| 10. CITY, TOWN OR LOCATION OF DEATH Riverdale | | | | 11. COUNTY OF DEATH Prince Georges | | | |
| 12a. STATE Maryland | | 12b. COUNTY Prince George's | | 12c. CITY, TOWN OR LOCATION Bowie | | 12d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 13a. STREET AND NUMBER 1125 Port Echo Lane | | | | 13b. ZIP CODE 20716 | | 13c. CITIZEN OF WHAT COUNTRY? United States | |
| 14. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 15. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 17. RACE — American Indian, Black, White, etc. Specify: Black | |
| 18. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College | | 19. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse's Aide | | 20. KIND OF BUSINESS/INDUSTRY Private | | | |
| 21. FATHER'S NAME (First, Middle, Last) James Alfred Tennant | | | | 22. MOTHER'S NAME (First, Middle, Maiden Surname) Rebecca De Montagnac | | | |
| 23. INFORMANT'S NAME (Type/Print) Diana Morrell | | | | 24. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13930 SouthWest 93rd. Lane Miami, Florida 33186 | | | |
| 25. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 26. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) All Souls Church Cemetery | | 27. LOCATION — City or Town, State Jamaica | | | |
| 28. SIGNATURE OF FUNERAL SERVICE LICENSEE Jimmy L. Neal | | 29. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, Maryland 20785 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CAUDIC ARREST DUE TO (OR AS A CONSEQUENCE OF): b. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASPIRATION PNEUMONIA DIABETES MELLITUS STATUS POST CEREBROVASCULAR ACCIDENT | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 29. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Michael P. Moray | | | | 29c. LICENSE NUMBER D 36860 | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Perry Talbert</i> | | | | 2. DATE OF DEATH MONTH <i>5</i> DAY <i>11</i> YEAR <i>90</i> | | 3. TIME OF DEATH <i>5:25 A.M.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>218-48-1154</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>40</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>3/17/1950</i> | |
| 8. FACILITY NAME (If not institution, give street and number) <i>Sinai Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Balt. Md.</i> | | 9c. COUNTY OF DEATH <i>Balt. City</i> | |
| 10a. STATE <i>Md.</i> | | | | 10b. COUNTY <i>Balt. City</i> | | 10c. CITY, TOWN OR LOCATION <i>Balt. City</i> | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER <i>3400 Virginia Ave</i> | | 10f. ZIP CODE <i>21215</i> | |
| 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Teacher</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY | | 17. FATHER'S NAME (First, Middle, Last) <i>Adolph Talbert</i> | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Hilma Talbert</i> | | | | 19a. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3400 Virginia Ave - Balt. Md. 21215</i> | | 19b. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20a. PLACE OF DISPOSITION (Name of cemetery, crematory or) | | | | 20b. LOCATION — City or Town, State <i>Balt. County, Md.</i> | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Carroll</i> | |
| 22. NAME AND ADDRESS OF FACILITY <i>John Carroll Funeral Home 1212-14th St. N.W. Wash. D.C.</i> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>PCP</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>2 basal ganglia infarct</i> b. <i>AIDS</i> c. <i>Due to (OR AS A CONSEQUENCE OF):</i> d. <i>Due to (OR AS A CONSEQUENCE OF):</i> | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julianne M. Berta M.D. PG-YI</i> | | | | 29c. LICENSE NUMBER <i>9330</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>5/11/90</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Julianne M. Berta Sinai Hospital</i> | | | | | | | |
| 31. DATE FILLED (Month, Day, Year) <i>MAY 14 1990</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Carroll</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13182

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--------------------|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM H. VERZIER | | | | 2. DATE OF DEATH MONTH DAY YEAR May 11, 1990 | | 3. TIME OF DEATH 3:00 AM | |
| 4. SOCIAL SECURITY NUMBER 044-20-8662 | | 5. SEX XX M 2 F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7-31-1927 | |
| 8. BIRTHPLACE (State or Foreign Country) Connecticut | | | | 9a. FACILITY NAME (If not institution, give street and number) Dulaney Towson Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | |
| 9c. COUNTY OF DEATH Baltimore Co. | | | | 10a. STATE Maryland | | 10b. COUNTY ----- | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? XX YES 2 NO | | 10e. STREET AND NUMBER 104 E. Gittings Street | |
| 10f. ZIP CODE 21230 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4X Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1X YES 2 NO IF YES, GIVE WAR OR DATES Korean Conflict | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 10 Years ----- | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bartender | | 16b. KIND OF BUSINESS/INDUSTRY Bar | |
| 17. FATHER'S NAME (First, Middle, Last) Harold Verzier, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Nolan | | | |
| 19a. INFORMANT'S NAME (Type/Print) Scott W. Verzier | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 20 North Carey Street Baltimore, Maryland | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2X Cremation 3 Removal from State 4 Donation 8 Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William E. Johnson | | | | 22. NAME AND ADDRESS OF FACILITY William E. Johnson, P.A. Funeral Home 8521 Loch Raven Blvd. Towson, MD 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cancer of oropharynx DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death Month ✓ |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2X NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4X Nursing Home 5 Residence 6 Other (Specify) | | | | 27. MANNER OF DEATH 1X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF PHYSICIAN Mark I. Lewer, MD | | | | 29c. LICENSE NUMBER D17041 | | 29d. DATE SIGNED (Month, Day, Year) 11 MAY 90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark I. Lewer, MD 7600 Oster Dr 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ED 40105

Dr. Barry Gold to sign death certificate
484-5640

90 13183

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|-----------------------|---|-----------------------------|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Edith Vaughn | | | | 2. DATE OF DEATH 5-10-90 DAY YEAR | | 3. TIME OF DEATH 5 15 P.M. | | | |
| 4. SOCIAL SECURITY NUMBER 216-34-6770 | | 5. SEX 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH 11-3-1932 | | 8. BIRTHPLACE (State or Foreign) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Balto. County General | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Balto. | | | 9c. COUNTY OF DEATH Balto | | |
| 10a. STATE Md. | | | 10b. COUNTY Balto. | | 10c. CITY, TOWN OR LOCATION | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 51 Tallow Ct. | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cashier | | 16b. KIND OF BUSINESS/INDUSTRY Can | | | |
| 17. FATHER'S NAME (First, Middle, Last) Robert F. Harris | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie Giles | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) James Vaughn | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 51 Tallow Ct. Balto. Md. 21207 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem. | | 20c. LOCATION — City or Town, State Balto. Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Carlton C. Vaughan | | | | 22. NAME AND ADDRESS OF FACILITY Douglass Funeral Service 1701 McCulloh St. | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial infarct DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 5/10/90 | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Barry S Gold M.D. M.P.A. | | | | 29c. LICENSE NUMBER D19158 | |
| 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Barry S Gold M.D. 122 SNOE AVE Suite 301 Balto, Md 21208 | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | | | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY E WASHINGTON | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 8, 1990 | | 3. TIME OF DEATH 7:50 P M | |
| 4. SOCIAL SECURITY NUMBER 218-03-0285 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03-13-23 | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE CITY | |
| 10a. STATE Maryland | | 10b. COUNTY none | | 10c. CITY, TOWN OR LOCATION Baltimore City | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 201 N. Washington Street | | | | 10f. ZIP CODE 21231 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Negro | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeper | | 16b. KIND OF BUSINESS/INDUSTRY Private Homes | | | |
| 17. FATHER'S NAME (First, Middle, Last) Fait Hall | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Allen | | | |
| 19a. INFORMANT'S NAME (Type/Print) Edna Spearman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1501 E. Lafayette Avenue, Balto, Md. 21213 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) VOSHALL MEMORIAL GARDENS | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gladys Warner | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH F.H. 1101 E. NORTH AVE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. CHRONIC ACTIVE HEPATITIS 3yrs. 3yrs | | | | | | | |
| b. HEPATITIS C (HEPATITIS C) 3yrs | | | | | | | |
| c. COAGULOPATHY (COAGULOPATHY) 1 week 1wk | | | | | | | |
| d. ENCEPHALOPATHY (ENCEPHALOPATHY) 1wk. 1wk | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| HTN (HTN) Anemia (Anemia) | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Linda Mundy MD | | | | 29c. LICENSE NUMBER F0002 | | 29d. DATE SIGNED (Month, Day, Year) 5/8/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Linda Mundy MD JHH 600 N. Wolfe St. JHH 600 N Wolfe St. Balt MD 21205 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Roy V. Williams | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 10, 1990 | | 3. TIME OF DEATH 5:00 A M | |
| 4. SOCIAL SECURITY NUMBER 229-07-0446 | | 6. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5/3/09 | |
| 9a. FACILITY NAME (If not institution, give street and number) 3625 GRIER NURSERY RD. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH STREET | | 9c. COUNTY OF DEATH HARFORD | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY HARFORD | | 10c. CITY, TOWN OR LOCATION STREET | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3625 GRIER NURSERY RD. | | | | 10f. ZIP CODE 21154 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SEXTON | | 16b. KIND OF BUSINESS/INDUSTRY CHURCH | |
| 17. FATHER'S NAME (First, Middle, Last) GROVER C. WILLIAMS | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZA STUMP | | | |
| 19a. INFORMANT'S NAME (Type/Print) MILDRED J. WILLIAMS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3625 GRIER NURSERY RD., STREET, MD., 21154 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BEL AIR MEMORIAL GARDENS | | 20c. LOCATION — City or Town, State BEL AIR, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jeffrey P. Lovelidge</i> | | | | 22. NAME AND ADDRESS OF FACILITY HARKINS F.H. INC, 600 MAIN ST, DELTA, PA. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. - Renal Failure 2° to Prostate Cancer. Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>J.K. Lynch</i> | | | | 29c. LICENSE NUMBER D35012 | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KEVIN J. LYNCH, BOULTON ST., BEL AIR, MD. | | | | | | | |
| 31. DATE MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


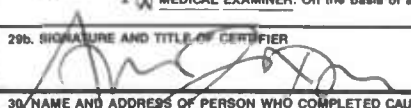
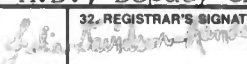
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARGARET M. ANTONELLI | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 10:46 A M | |
| 4. SOCIAL SECURITY NUMBER 212-07-9722 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JAN. 6 1917 | |
| 9a. FACILITY NAME (If not institution, give street and number) 525 N. Ellwood Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH MD. | |
| 10a. STATE MD. | | 10b. COUNTY ----- | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 525 N. ELLWOOD AVE. | | | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH HAJEK | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH | | | |
| 19a. INFORMANT'S NAME (Type/Print) CAMILLO ANTONELLI (HUSBAND) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 N. ELLWOOD AVE., BALTIMORE, MD. 21205 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MOST HOLY REDEEMER CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | 22. NAME AND ADDRESS OF FACILITY SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Baltimore, Md. 21213 | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Inspection 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ODA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-12-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann M. Dixon, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 v1 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
|--|--|--|--|--|--|--|--|---|--|---|--|---|--|--------------------------------------|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Sister Claire Cecilia Ault | | | | | | | | 2. DATE OF DEATH MONTH DAY YEAR May 9, 1990 | | | | 3. TIME OF DEATH HOUR MIN 9:15 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 213-60-1327 | | | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 21, 1907 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Villa Assumpta, 6401 N. Charles | | | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH St. Baltimore | | | | 9c. COUNTY OF DEATH Baltimore | | | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 6401 N. Charles St. | | | | | | | | 10f. ZIP CODE 21212 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4+ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | | | | 16b. KIND OF BUSINESS/INDUSTRY Education | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) George Henry Ault | | | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Clare Bernadine Gallagher | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) S. Bernice Feilinger | | | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 N. Charles St., Baltimore, Md. 21212 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other) Villa Maria Cemetery | | | | 20c. LOCATION — City or Town, State Glen Arm, Maryland | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL HOME LICENSEE <i>Dennis Stephen Xenakis</i> Dennis Stephen Xenakis | | | | | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute MI. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Atherosclerotic cardiovascular disease PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition Severe Depression | | | | | | | | | | | | Approximate interval Between Onset and Death | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lawrence Boas</i> | | 29c. LICENSE NUMBER D15871 | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Lawrence Boas, M. D. 54 Scott Adam Road, Cockeysville, Md. 21030 | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Anderson</i> | | | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROSALIE MARY ALLEN | | | | 2. DATE OF DEATH MONTH 5 DAY 13 YEAR 90 | | 3. TIME OF DEATH 6:08 PM | |
| 4. SOCIAL SECURITY NUMBER 213-28-3088 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 59 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1 14 31 | |
| 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Med. Cntr. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Maryland | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7209 Fait Avenue | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) _____ | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) REtired | | 16b. KIND OF BUSINESS/INDUSTRY Crown Cork & Seal Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Elmer Wisner | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Roseann Wienger | | | |
| 19a. INFORMANT'S NAME (Type/Print) Charles R. Allen | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7209 Fait Avenue - Baltimore, MD. 21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 5/16/90 - Oak Lawn Cemetery | | 20c. LOCATION — City or Town, State Baltimore, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Walter L. Dabrowski | | | | 22. NAME AND ADDRESS OF FACILITY Walter Dabrowski Funeral Chapel 1005 Dundalk Ave., Balto., Md. 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Multisystem Failure DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. PANCREATITIS DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input checked="" type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 3/1/90 | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED During Endoscopy | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FSK | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER LITMAN | | | | 29c. LICENSE NUMBER AF2664230-SL | | 29d. DATE SIGNED (Month, Day, Year) 5/13 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEVEN A. LITMAN M.D. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WELDON ROSS BRADSHAW | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 14 90 | | 3. TIME OF DEATH 10A M | |
| 4. SOCIAL SECURITY NUMBER 218 10 2556 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-16-1914 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH ==== | | | | 10a. STATE Maryland | | | |
| 10b. COUNTY Anne Arundel | | | | 10c. CITY, TOWN OR LOCATION Baltimore | | | |
| 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | 10e. STREET AND NUMBER 618 Sunset Strip | | | |
| 10f. ZIP CODE 21225 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES World War II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 7TH GRADE | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Enameler | | 16b. KIND OF BUSINESS/INDUSTRY Am. Standard Radiator | |
| 17. FATHER'S NAME (First, Middle, Last) Walton Bradshaw | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Evans | | | |
| 19a. INFORMANT'S NAME (Type/Print) Elsie M. Bradshaw | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 618 Sunset Strip Baltimore, Maryland 21225 | | | |
| 20a. METHOD OF DISPOSITION 1 BURIAL 2 CREMATION 3 REMOVAL FROM STATE 4 DONATION 5 OTHER (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>C. Puhar</i> | | | | 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic carcinoma of breast | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): Respiratory failure probably 2nd to Metastasis | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD HTF | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5 14 90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SYED M. A. RIZ 1301 Lincoln Woods Dr. Balti 21228 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) BETTY L. BANKS | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-10-90 | | 3. TIME OF DEATH 10:10 A M | | |
| 4. SOCIAL SECURITY NUMBER 212-34-3157 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 54 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 9, 1935 | | |
| 9a. FACILITY NAME (If not institution, give street and number) Baltimore County General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown | | 9c. COUNTY OF DEATH Baltimore | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | |
| 10e. STREET AND NUMBER 4127 Callaway | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nursing Assistant | | 16b. KIND OF BUSINESS/INDUSTRY Medical- Spring Grove | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Herbert Coleman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Arizona Brooks | | | | |
| 19a. INFORMANT'S NAME (Type/Print) William S. Banks | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4127 Callaway Ave. Baltimore, Maryland 21215 | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery | | 20c. LOCATION — City or Town, State Baltimore County, MD | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vernon R. Banley | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | |
| a. Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Myocardial Infarction, massive DUE TO (OR AS A CONSEQUENCE OF): c. Coronary atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): d. Pulmonary thromboemboli DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| e. Diabetic mellitus type II DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER David J. Miller M.D. | | | | 29c. LICENSE NUMBER 206980 | | 29d. DATE SIGNED (Month, Day, Year) May 10 - 1990 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David J. Miller 10719 South Delford Rd. Owing Mills, MD | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


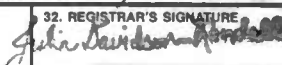
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ELSIE JULIA BORLAND | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 11 1990 | | 3. TIME OF DEATH 825 A M | |
| 4. SOCIAL SECURITY NUMBER 212-24-9042 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 3, 1896 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington, D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH Baltimore City | | | | 10a. STATE Maryland | | | |
| 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Linthicum | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 206 West Maple Road | | | | 10f. ZIP CODE 21090 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self-Employed | | 16b. KIND OF BUSINESS/INDUSTRY Restaurant | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Damm | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosa Dreis | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorothy R. Omanski | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 Kingwood Road, Linthicum, Maryland 21090 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore National Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Singleton Funeral Home 1 Second Ave. S.W., Glen Burnie, Md. 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. A. P. Mansury MD HOUSE OFFICER PG4 III | | | | 29c. LICENSE NUMBER D38873 | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. P. MANSURY MD HARBOR HOSPITAL 3001 S. HANOVER ST BAL MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90/3/92

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate.



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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) James Brown (JAMES R. BROWN) | | | | 2. DATE OF DEATH MONTH 5 DAY 10 YEAR 90x | | 3. TIME OF DEATH 1:20 PM | |
| 4. SOCIAL SECURITY NUMBER 223-24-7104 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 08-17-25 | |
| 8. BIRTHPLACE (State or Foreign Country) VA. | | | | 9a. FACILITY NAME (If not institution, give street and number) Church Hospital Corporation | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE Md. | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION Baltimore City | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1903 FAIRMOUNT Ave. | |
| 10f. ZIP CODE 21231 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th GRADE College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY A-1 PLATING CO. | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES BROWN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) WILHELMINA JONES | | | |
| 19a. INFORMANT'S NAME (Type/Print) PHYLLIS BROWN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1903 E. FAIRMOUNT AVE. BALTO, MD. 21231 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladys Wanner | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. POSSIBLE PULMONARY EMBOLISM DUE TO (OR AS A CONSEQUENCE OF): b. DISSEMINATED INTRAVASCULAR COAGULOPATHY DUE TO (OR AS A CONSEQUENCE OF): c. METASTATIC CA, UNKNOWN PRIMARY DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Beena Nagpal MD. | |
| 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Beena Nagpal MD. 100 Broadway Church Hospital | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH J. BAHUR | | | | 2. DATE OF DEATH MONTH 5 DAY 19 YEAR 1990 | | 3. TIME OF DEATH 14:35 PM | |
| 4. SOCIAL SECURITY NUMBER 212 227582 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12/25/27 | |
| 9a. FACILITY NAME (If not institution, give street and number) FRANCIS SCOTT KEY | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH Md. | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1309 Bonsal Street | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES ARMY | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) VOCATIONAL College (1-4 or 5+) U.S. Gov't. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) U.S. Gov't. | | 16b. KIND OF BUSINESS/INDUSTRY Audio Visual Maint. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Arthur R. Demski | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) U.K. | | | |
| 19a. INFORMANT'S NAME (Type/Print) Bruce Bahur | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1309 Bonsal Street - Baltimore, Md. 21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hills Cemetery 5/12/90 | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Walter E. Dabrowski | | | | 22. NAME AND ADDRESS OF FACILITY Walter Dabrowski Funeral Chapel 1005 Dundalk Avenue - Baltimore, Md. 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. CARDIOPULMONARY FAILURE | | | | | | 6 hrs | |
| b. SKULL FRACTURE | | | | | | 18 hrs | |
| c. INTRACRANIAL BLEED | | | | | | 18 hrs | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| d. HEPATIC METASTASES | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PAST CEREBRAL VASCULAR ACCIDENTS | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 5/18/90 | | 28b. TIME OF INJURY 5:18 PM | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME | | 28e. DESCRIBE NOW INJURY OCCURRED FALL DOWN STAIRS | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) HOME | | | | | |
| 29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER STEVE LITMAN M.D. | | | | 29c. LICENSE NUMBER AF2664200-SL | | 29d. DATE SIGNED (Month, Day, Year) 5/19/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEVE LITMAN M.D. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) SMAX 15 1990 | | 32. REGISTRAR'S SIGNATURE John B. ... | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Marie Baumann | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-13-90 | | 3. TIME OF DEATH 11:25PM M | |
| 4. SOCIAL SECURITY NUMBER 216-09-0476 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-26-10 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore, Maryland | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 609 47 th Street - Baltimore, Md. 21224 | | 10f. ZIP CODE 21224 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired | | | | 16b. KIND OF BUSINESS/INDUSTRY CRown Cork & Seal Co. | | 17. FATHER'S NAME (First, Middle, Last) Harry Dasch | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Stoeuer | | | | 19a. INFORMANT'S NAME (Type/Print) John Baumann | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 47 th Street - Baltimore, Md. 21224 | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 5/16/90 Oak Lawn Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Walter G. Dabrowski | | | | 22. NAME AND ADDRESS OF FACILITY Walter Dabrowski Funeral Chapel 1005 Dundalk Avenue, Baltimore, Md. 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ruptured Thoracic Aortic Aneurysm DUE TO (OR AS A CONSEQUENCE OF): b. hypertensive arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Partial Gastrectomy for peptic ulcer disease | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Frank Peretti, MD | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-14-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frank Peretti, MD 111 Penn Street, Baltimore, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) GEORGE L BOHANAN, JR. | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 10 90 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 55 212 20 3855 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 63 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 01 16 27 | 8. BIRTHPLACE (State or Foreign Country) MD | |
| 9a. FACILITY NAME (If not institution, give street and number) ST JOSEPH'S HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE - TOWSON | | 9c. COUNTY OF DEATH MD - BALTIMORE | |
| 10a. STATE MD | | | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION Long Green - 12656 Manor Rd. | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 12656 MANOR RD | | 10f. ZIP CODE 21092 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 YRS. College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ROOFER | | 16b. KIND OF BUSINESS/INDUSTRY FICK ROOFING CO. | |
| 17. FATHER'S NAME (First, Middle, Last) GEORGE L. BOHANAN, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH EBERWEIN | | | |
| 19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE. | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY | | 20c. LOCATION — City or Town, State PARKVILLE MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dale J. Henry | | | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIALS 8300 HARFORD ROAD - PARKVILLE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest. DUE TO (OR AS A CONSEQUENCE OF): Status Asthmaticus DUE TO (OR AS A CONSEQUENCE OF): Chronic Bronchial Asthma. DUE TO (OR AS A CONSEQUENCE OF): COPD Hypertension | | | | | | | Approximate Interval Between Onset and Death 30-45m. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) TOWSON, MD 21204 | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M.D. | | | | 29c. LICENSE NUMBER D24722 | | 29d. DATE SIGNED (Month, Day, Year) 5.10.90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 6919 HARFORD ROAD, BALTIMORE, MD 21234 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOYCE JEAN BARROW | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 09 90 | | 3. TIME OF DEATH 10 15 P.M. | |
| 4. SOCIAL SECURITY NUMBER 571-30-5474 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH MONTH DAY YEAR JUNE 6, 1927 | |
| 8. BIRTHPLACE (State or Foreign Country) CALIFORNIA | | | | 9a. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| 9b. FACILITY NAME (If not institution, give street and number) FRANCIS SCOTT KEY MEDICAL CENTER | | | | 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | |
| 10c. CITY, TOWN OR LOCATION DUNDALK | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 2013 JASMINE ROAD | |
| 10f. ZIP CODE 21222 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4 or 5+) N/A | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TELETYPE OPERATOR | | 16b. KIND OF BUSINESS/INDUSTRY SEARS & ROEBUCK | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLES FISMAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARTHA NOT KNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print) WILLIAM K. BARROW | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2013 JASMINE ROAD BALTIMORE, MARYLAND 21222 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) OAK LAWN CEMETERY 5-14-1990 | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE P. Gardner | | | | 22. NAME AND ADDRESS OF FACILITY DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → end stage lung disease (COPD) DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Shelley Gardner Senior Assistant Registrar | | | | 29c. LICENSE NUMBER 39102 | | 29d. DATE SIGNED (Month, Day, Year) May 9, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Madeline Collins | | | | 2. DATE OF DEATH MONTH 5 DAY 2 YEAR 1990 | | 3. TIME OF DEATH 10:50 A M | |
| 4. SOCIAL SECURITY NUMBER 217-07-1570 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7/14/03 | |
| 9a. FACILITY NAME (If not institution, give street and number) Pleasant Manor Nursing Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH 4615 Pk. Hgts. Ave. | | 9c. COUNTY OF DEATH Baltimore, Md. | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 4615 Pk. Hgts. Ave. | | | |
| 10f. ZIP CODE 21215 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) UnKn | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UnKn | | | |
| 19a. INFORMANT'S NAME (Type/Print) Rachel Holmes | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1518 N. Calhoun Street 21213 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MT Calvary Cem. | | 20c. LOCATION — City or Town, State Balt. Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeff Miller | | | | 22. NAME AND ADDRESS OF FACILITY Jeff Miller #1 1639 N. Broadway 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple C.V.A.'s a. DUE TO (OR AS A CONSEQUENCE OF): ASCVD b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 2 yrs. 10 yrs. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SIPAKA - Left in garage w/ (L) foot Decubitus ulcer - (L) thigh Arrhythmia + Heart Failure | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Jamie Punzalan MD | | | | 29c. LICENSE NUMBER D15124 | | 29d. DATE SIGNED (Month, Day, Year) 5/3/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. PUNZALAN - 5214 Harford rd. Balt. Md. 21214 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Frank J. Culotta Sr.</i> | | | | 2. DATE OF DEATH MONTH <i>5</i> DAY <i>10</i> YEAR <i>90</i> | | 3. TIME OF DEATH <i>15 20</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>212 20 7635</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>74</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>2-10-1916</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>St. Agnes Hospital</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i> | |
| 9c. COUNTY OF DEATH <i>=====</i> | | | | 10a. STREET AND NUMBER <i>2708 Robin Road</i> | | | |
| 10b. STATE <i>Maryland</i> | | 10c. COUNTY <i>Anne Arundel</i> | | 10d. CITY, TOWN OR LOCATION <i>Glen Burnie</i> | | 10e. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10f. ZIP CODE <i>21061</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>World War II</i> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th Grade</i> | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Electronics Tech.</i> | | 15b. KIND OF BUSINESS/INDUSTRY <i>U.S. Government</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>W Vincent Culotta</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Marion Zito</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Marie Culotta</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2708 Robin Road Glen Burnie, Maryland 21061</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>New Cathedral Cemetery</i> | | 20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donna M. Zramisowski</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory Failure</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Adenocarcinoma of the lung</i> c. d. Approximate interval Between Onset and Death <i>2 yrs</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>Wm. C. Waterfield MD</i> | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wm. C. Waterfield MD</i> | | 29c. LICENSE NUMBER <i>A24356</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>5/10/90</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Wm. C. Waterfield MD St Agnes Hospital 900 Caton Ave Baltimore 21229</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 15 1990</i> | | 32. REGISTRAR'S SIGNATURE <i>Julia Seidenman</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Warren CLARK Hayman, Jr. | | 2. DATE OF DEATH MONTH DAY YEAR 5-8-90 | | 3. TIME OF DEATH 12:25AM M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 549-37-3379 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 28 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 6, 1962 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 2000 block Madison Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | | 9c. COUNTY OF DEATH | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 1663 Forest Park Ave. | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Representative | | 16b. KIND OF BUSINESS/INDUSTRY Baltimore Gas & Electric | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Warren Clark Hayman, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jacqueline Campbell | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lori B. Hayman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1663 Forest Park Ave. Apt. C4 Balto., MD 21207 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park | | 20c. LOCATION — City or Town, State Baltimore County, MD | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Herker E. Nutter | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple gunshot wounds DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Scene | | 26. PLACE OF DEATH (Check only one) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 5-8-90 | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED Subject shot | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) street | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2000 block Madison Ave. Balto. MD | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Mario F. Golle, Jr., MD | | | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-8-90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mario F. Golle, Jr., MD 111 Penn Street, Baltimore, MD 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Waverly Campbell</u> | | | | 2. DATE OF DEATH MONTH <u>5</u> DAY <u>13</u> YEAR <u>90</u> | | 3. TIME OF DEATH <u>0100 A.M.</u> | |
| 4. SOCIAL SECURITY NUMBER <u>224-44-2835</u> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>54</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>10/4/35</u> | |
| 8. BIRTHPLACE (State or Foreign Country) <u>Virginia</u> | | | | 9a. FACILITY NAME (If not institution, give street and number) <u>Liberty Medical Center</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u> | |
| 9c. COUNTY OF DEATH <u>Maryland</u> | | | | 10a. STATE <u>Maryland</u> | | 10b. COUNTY <u>Baltimore City</u> | |
| 10c. CITY, TOWN OR LOCATION <u>Baltimore City</u> | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER <u>901 Druid Lake Dr, 5F</u> | |
| 10f. ZIP CODE <u>21216</u> | | | | 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u> | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>College (1-4 or 5+)</u> | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>David Campbell Sr.</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Bessie Mansfield</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>David Campbell Jr.</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2665 Oswego Avenue Balto., MD 21215</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Loudon Park Cemetery</u> | | | |
| 20c. LOCATION — City or Town, State <u>Baltimore, Maryland</u> | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Leroy O. Dyett</u> | | | |
| 22. NAME AND ADDRESS OF FACILITY <u>LEROY O. DYETT & SON FUNERAL HOME</u> <u>4600 LIBERTY HEIGHTS AVENUE</u> | | | | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ALCOHOLIC LIVER DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>HEPATIC ENCEPHALOPATHY</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Pneumonia with Respiratory Failure</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Renal Failure</u> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M <u>1</u> <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <u>B. Kutsche MD</u> | | | |
| 29c. LICENSE NUMBER <u>D 35788</u> | | | | 29d. DATE SIGNED (Month, Day, Year) <u>5/13/90</u> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>B. Kutsche MD LIBERTY MEDICAL CENTER</u> <u>LIBERTY HEIGHTS BALT. MD 21215</u> | | | | 31. DATE FILED (Month, Day, Year) <u>MAY 15 1990</u> | | | |
| 32. REGISTRAR'S SIGNATURE <u>J. Davidson</u> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MILDRED COOPER | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 09 90 | | 3. TIME OF DEATH 1040 A M | |
| 4. SOCIAL SECURITY NUMBER 217-40-3819 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 02-27-05 | |
| 9a. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5200 ELMER AVENUE | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) RICHARD POULSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) FANNIE POULSON | | | |
| 19a. INFORMANT'S NAME (Type/Print) PATRICIA HOLSEY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5200 ELMER AVENUE: BALTO., MD. 21215 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MT. AUBURN CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i> | | | | 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME, INC. 4600 LIBERTY HEIGHTS AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → POSS. MYOCARDIAL INFARCTION. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DEHYDRATION c. CEREBRAL ATROPY with Dementia | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - HYPERCALCEMIA - SCHIZOPHRENIA | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sudhir D. Patel MD.</i> | | | | 29c. LICENSE NUMBER D 23300 | | 29d. DATE SIGNED (Month, Day, Year) 05-09-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SUDHIR D. PATEL 2600 LIBERTY RD. BALTO. MD. 21215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

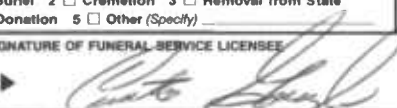
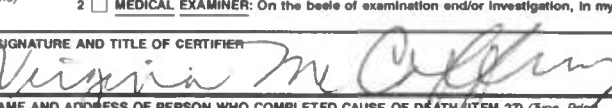
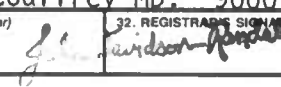
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20 12505

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary Bily | | | | 2. DATE OF DEATH MONTH DAY YEAR May 12, 1990 | | 3. TIME OF DEATH 5:50 A | |
| 4. SOCIAL SECURITY NUMBER 220-44-1156 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JAN 19, 1901 | |
| 8. BIRTHPLACE (State or Foreign Country) BOHEMIA | | | | 9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 7526 BATTLE GROVE CIRCLE | |
| 10f. ZIP CODE 21222 | | | | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NA College (1-4 or 5+) NA | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH SCHRAMEK | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY KUZAK | | | |
| 19a. INFORMANT'S NAME (Type/Print) CHARLES SCHRAMEK (BROTHER) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7526 BATTLE GROVE CIRCLE, BALTO., MD. 21222 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BOHEMIAN NATIONAL CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY SCHIMUNEK FUNERAL HOMES, INC. 3331 BREHMS LANE, BALTO, MD. 21213 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Severely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Severe Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): b. Bladder Cancer DUE TO (OR AS A CONSEQUENCE OF): c. Ovarian Cancer DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  Virginia McCaffrey MD. | | | | 29c. LICENSE NUMBER N/A | | 29d. DATE SIGNED (Month, Day, Year) 5-12-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Virginia McCaffrey MD. 9000 Franklin Square Drive 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) <u>WALTER CARTER Carter</u> | | | | 2. DATE OF DEATH MONTH <u>May</u> DAY <u>11</u> YEAR <u>1990</u> | | 3. TIME OF DEATH <u>M</u> | |
| 4. SOCIAL SECURITY NUMBER <u>215-28-4486</u> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>56</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>03-23-34</u> | |
| 8. BIRTHPLACE (State or Foreign Country) <u>Virginia</u> | | | | 9a. FACILITY NAME (If not institution, give street and number) <u>2000 Odell Avenue - Apt. 1603</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u> | |
| 9c. COUNTY OF DEATH <u>none</u> | | | | 10. RESIDENCE OF DECEASED | | | |
| 10a. STATE <u>Maryland</u> | | 10b. COUNTY <u>none</u> | | 10c. CITY, TOWN OR LOCATION <u>Baltimore City</u> | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <u>2000 Odell Ave. Apt. 1603</u> | | | | 10f. ZIP CODE <u>21237</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>United States</u> | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>Negroid</u> | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6th grade</u> | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>unemployed</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>none</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>James Carter</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Maude Bailey</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Clementine Whitehead</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>422 N. Castle St. Balto. Md. 21231</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Maryland National Memorial Pk/Laurel, Md.</u> | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Calvin B. Scruggs Jr.</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Calvin B. Scruggs Funeral Home</u> <u>1412 E. Preston Street, Balto. Md. 21213</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Uremia (uremia)</u> 1 year <u>1 year</u> | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| a. <u>Kidney failure</u> (Kidney failure) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>None</u> <u>None</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>Sheltered housing</u> | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Hary Soule MD</u> | | | | 29c. LICENSE NUMBER <u>D19805</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>5/14/90</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Gary Bisset MD</u> <u>4940 Eastern Ave, Balt, MD 21224</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>MAY 15 1990</u> | | | | 32. REGISTRAR'S SIGNATURE <u>J. Davidson</u> | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

90 13205

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Sol Zelig Cohen | | | | 2. DATE OF DEATH MONTH 5 DAY 10 YEAR 90 | | 3. TIME OF DEATH 1:45 PM | |
| 4. SOCIAL SECURITY NUMBER 579 07 2641 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH MONTH 3 DAY 30 YEAR 1910 | |
| 8. BIRTHPLACE (State or Foreign Country) New York | | | | 9. FACILITY NAME (If not institution, give street and number) Sharon Nursing Home | | | |
| 10. RESIDENCE OF DECEDENT | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Olney, MD | | 9c. COUNTY OF DEATH Montgomery Co. | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Olney | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 18201 Marden Lane | | | | 10f. ZIP CODE 20832 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 years College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Driver | | 16b. KIND OF BUSINESS/INDUSTRY Taxi Cab | |
| 17. FATHER'S NAME (First, Middle, Last) Max Cohen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida (unascertainable) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Leslie Murray Cohen | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6200 Westchester Park Drive, College Park, Maryland 20740 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Ohev Sholom Talmud Torah Congregation Cemetery Washington, DC | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald M. Stein</i> | | | | 22. NAME AND ADDRESS OF FACILITY DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C. | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Acute MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA OF ALZHEIMER TYPE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Howe</i> MD | | | | 29c. LICENSE NUMBER D33700 | | 29d. DATE SIGNED (Month, Day, Year) 5-10-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TED HOWE OLNEY, MARYLAND | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the funeral transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ETHELYN M. CRUM | | | | 2. DATE OF DEATH MONTH 05 DAY 09 YEAR 90 | | 3. TIME OF DEATH 01-30A M | |
| 4. SOCIAL SECURITY NUMBER 214 18 5020 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) OCT 17, 1922 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MARYLAND | | | |
| 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION DUNDALK | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 8036 WYNBROOK ROAD | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) AT Home | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) CARL LOUIS LETMATE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MAE D. KETTERS | | | |
| 19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MORELAND MEM PARK | | 20c. LOCATION — City or Town, State PARKVILLE MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF CHIMES 2325 YORK ROAD - TIMONIUM | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): a. Pulmonary Tuberculosis DUE TO (OR AS A CONSEQUENCE OF): c. Chronic obstructive Pulm. disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 2 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Joginder S. Jodha MD | | | | 29c. LICENSE NUMBER House officer | | 29d. DATE SIGNED (Month, Day, Year) 5/9/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOGINDER S. JODHA MD H.H. Center Baltimore MD 21230 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Leila, Mary, Collopy</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>5 12 90</i> | | 3. TIME OF DEATH <i>7:40 am</i> | |
| 4. SOCIAL SECURITY NUMBER <i>181-20-0396</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>86</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>5-14-03</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Stella Maris Hospice</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Towson</i> | | 9c. COUNTY OF DEATH <i>Baltimore</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Baltimore</i> | | 10c. CITY, TOWN OR LOCATION <i>Towson</i> | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>2300 Dulaney Valley Road</i> | | | | 10f. ZIP CODE <i>21204</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i> | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Charles Lawrence</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Nancy Green</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Rev. John C. Collopy</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Long Green Pike, Hydes, Maryland 21083</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Joseph's Fullerton Cem. 5/16/90</i> | | 20c. LOCATION — City or Town, State <i>Baltimore Md.</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael J. Suok</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Ruck Towson Funeral Home, Inc. 1050 York Rd</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Chronic Obstructive Pulmonary Disease</i> | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>11</i> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>5-12-90</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Eddie Hekuda M.D. 2300 Dulaney Valley Road Towson, Md. 21204</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 15 1990</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Judith Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HOWARD SAUNDERS DORSEY JR. | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 14 1990 | | 3. TIME OF DEATH M M | |
| 4. SOCIAL SECURITY NUMBER 214-24-2734 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 61 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 02/18/1929 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) 2534 MOLTON WAY | | 9b. CITY, TOWN OR LOCATION OF DEATH WOODLAWN | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | |
| 10c. CITY, TOWN OR LOCATION WOODLAWN | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 2534 MOLTON WAY | |
| 10f. ZIP CODE 21207 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS (SEPERATED) 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII US NAVY | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MACHINIST | | 16b. KIND OF BUSINESS/INDUSTRY NATIONAL DISTILLERY | |
| 17. FATHER'S NAME (First, Middle, Last) HOWARD S. DORSEY SR | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) PAULINE S. DICKERSON | | | |
| 19a. INFORMANT'S NAME (Type/Print) SHIRLEY EDWARDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2534 MOLTON WAY, BALTIMORE, MARYLAND 212107 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) WOODLAWN CEMETERY | | 20c. LOCATION — City or Town, State BALTO COUNTY MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harbert E. Nutter</i> | | | | 22. NAME AND ADDRESS OF FACILITY NUTTER FUNERAL HOMES, INC. 21216 2501 GWYNNS FALLS PKWY., BALTIMORE, MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Lung Cancer</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Severe bronchitis and</i> c. <i>emphysema</i> | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Harbert E. Nutter</i> physician | | | | 29c. LICENSE NUMBER D29769 | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Carrolline D. Albuerne 516 W. Rolling Rd Baltimore</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|---|---|
| 1. DECEASED'S NAME (First, Middle, Last) <i>Doris D. Brown</i> | | | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>5 11 90</i> | | 3. TIME OF DEATH <i>1:30 A.M.</i> | | |
| 4. SOCIAL SECURITY NUMBER <i>066-05-1872</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>85</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>12-25-04</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Va.</i> | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>IRVINGTON KNOLLS</i> | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTO MD</i> | | 9c. COUNTY OF DEATH | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | |
| 10a. STATE <i>Md.</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>Balto</i> | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER <i>301 McMecken St.</i> | | | | 10f. ZIP CODE <i>21217</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>B</i> | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Benjamin F. Johnson</i> | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Cora Lee Brown</i> | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Carol Johnson</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>10462 63 Metropolitan Oval Apt. 3F., Bronx, N.Y.</i> | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>King Mem. Pk.</i> | | 20c. LOCATION — City or Town, State <i>Randallstown, Md.</i> | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sala March</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>March F/H West 4300 Wabash Ave.</i> | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Recurrent Aspiration Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <i>b. Extensive CVA (Cerebrovascular Accident)</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i> | | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lester L. Lewis Jr. M.D.</i> | | 29c. LICENSE NUMBER <i>D29524</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>5/11/90</i> | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Lester L. Lewis Jr. M.D., 2200 Garrison Blvd. #303, Baltimore Md. 21246</i> | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 15 1990</i> | | 32. REGISTRAR'S SIGNATURE <i>Lester L. Lewis Jr.</i> | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

COSMOS 84

90 13210

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Ethlen Aletha Downes | | | | 2. DATE OF DEATH MONTH 05 DAY 13 YEAR 90 | | 3. TIME OF DEATH 4:05 P M | |
| 4. SOCIAL SECURITY NUMBER 076-07-7759 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 2 - 1906 | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Joseph's Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Cockeysville | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 10322 Malcolm Circle | | | | 10f. ZIP CODE 21030 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant | | 16b. KIND OF BUSINESS/INDUSTRY Accounting | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Hickey | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Sanders | | | |
| 19a. INFORMANT'S NAME (Type/Print) Arthur T. Berg, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 Bennett Place, Amityville, N. Y. 11701-3601 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem. | | 20c. LOCATION — City or Town, State Garrison, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Bryan W. Clary</i> Bryan W. Clary | | | | 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld Timonium, Maryland 21093 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiovascular Breeding Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Cardiac arrhythmias c. d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Hubert M. Bassi MD</i> | | | | 29c. LICENSE NUMBER D37250 | | 29d. DATE SIGNED (Month, Day, Year) 5/13/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ASHWAN K. BASSI MD ST. JOSEPH HOSPITAL BALTO. Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John L. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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10352290-0107

DORSEY LAWRENCE

04/17/90 REGAL

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) LAWRENCE DORSEY | | | | 2. DATE OF DEATH MONTH 5 DAY 9 YEAR 90 | | 3. TIME OF DEATH 3:30 A M | |
| 4. SOCIAL SECURITY NUMBER 217-05-7502 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 14, 1900 | |
| 9a. FACILITY NAME (If not institution, give street and number) SIANI Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Balto. City | | 9c. COUNTY OF DEATH MD. | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Balto. | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3908 Milford Ave | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: B | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Brick layer | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Henry Dorsey | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Wilmer | | | |
| 19a. INFORMANT'S NAME (Type/Print) Terri L. Richardson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1325 W. LANVALE ST. Balto., MD 21217 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) KING Memorial Park | | 20c. LOCATION — City or Town, State Balto. County, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wm C. Brown | | | | 22. NAME AND ADDRESS OF FACILITY 1206 W. North Ave William C. Brown Community FH | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic Obstructive Pulmonary Disease | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure Non sustained Ventricular Tachycardia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M.B., B.S. | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/9/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VINCENT KWOK KUEN TAM SINAI HOSPITAL OF BALTIMORE | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE VINCENT KWOK KUEN TAM | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Chatham, Samuel D. | | | | 2. DATE OF DEATH MONTH 5 DAY 5 YEAR 90 | | 3. TIME OF DEATH 5:15 M | |
| 4. SOCIAL SECURITY NUMBER 215-22-8956 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH MONTH 11 DAY 18 YEAR 28 | |
| 8a. FACILITY NAME (If not institution, give street and number) LEVINONE HEBERGER PATRIC CTR & HOSP | | | | 8b. CITY, TOWN OR LOCATION OF DEATH BALTO CITY | | 8c. COUNTY OF DEATH BALTO CITY | |
| 9. RESIDENCE OF DECEDENT | | | | 10a. STATE MD | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3505 SPALDING AVE | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMOED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) SAMUEL CHEATHAM | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MATTIE BUTLER | | | |
| 19a. INFORMANT'S NAME (Type/Print) LAURA SCOTT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2015 EHING STREET BALTIMORE, MD 21217 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR Cem. | | 20c. LOCATION — City or Town, State CATONSVILLE MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Berry Harris | | | | 22. NAME AND ADDRESS OF FACILITY CHATMAN - Harris F.H. BALTO, MD 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death wks yrs. |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Aspiration pneumonia | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): Cerebrovascular accident | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Steven J. Jensen MD | | | | 29c. LICENSE NUMBER D18186 | | 29d. DATE SIGNED (Month, Day, Year) 5/6/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH LEO DONLIN | | | | 2. DATE OF DEATH MONTH 05 DAY 13 YEAR 90 | | 3. TIME OF DEATH 3:45 P.M. | |
| 4. SOCIAL SECURITY NUMBER 214 14 8084 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-23-02 | |
| 9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 6231 NORTHWOOD DRIVE | | | |
| 10f. ZIP CODE 21212 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Quality Control Inspector | | 16b. KIND OF BUSINESS/INDUSTRY Federal Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) John P.F. Donlin | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Brigid O'Conner | | | |
| 19a. INFORMANT'S NAME (Type/Print) Alzene P. Donlin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6231 Northwood Dr. Baltimore, Maryland 21212 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens | | 20c. LOCATION — City or Town, State Lutherville, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dennis Stephen Xenakis | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acidosis DUE TO (OR AS A CONSEQUENCE OF): b. Pulmonary Edema DUE TO (OR AS A CONSEQUENCE OF): c. CHF DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus, h/o angina, IEMT | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M. A. Hanlon | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5-13-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. A. Hanlon Good Samaritan | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13214

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Gladys Marie Boyle DeVries | | | | 2. DATE OF DEATH MONTH 5 - DAY 11 - YEAR 90 | | 3. TIME OF DEATH 4 a.m. | |
| 4. SOCIAL SECURITY NUMBER 214-36-8091 | | 6. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6-26-02 | |
| 9a. FACILITY NAME (If not institution, give street and number) Meridian Long Green Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore County | | 10c. CITY, TOWN OR LOCATION Rodger's Forge | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 226 B Rodger's Forge Road | | | | 10f. ZIP CODE 21212 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Boyle | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lenora | | | |
| 19a. INFORMANT'S NAME (Type/Print) John DeVries | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 N. Tyrone Road Baltimore, Maryland 21212 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery | | 20c. LOCATION — City or Town, State Pikesville, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE John C. Reitz | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute stroke Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Progressive Systemic Sclerosis 15 yr | | | | | | | Approximate Interval Between Onset and Death — |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 2 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Gregory J. St. Laurent | | | | 29c. LICENSE NUMBER D25662 | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3303 N. Calverly Rd BALTO MD 21218 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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90 13215

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RUTH ELMIRA DAY | | | | 2. DATE OF DEATH MONTH 5 DAY 9 YEAR 90 | | 3. TIME OF DEATH 10:55A M | |
| 4. SOCIAL SECURITY NUMBER 212-30-0703 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-18-98 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Meridian Long Green | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH N/A | | | | 10a. STATE Maryland | | 10b. COUNTY N/A | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 5610 York Road | |
| 10f. ZIP CODE 21212 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS XXX Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Librarian | | 16b. KIND OF BUSINESS/INDUSTRY Enoch Pratt | |
| 17. FATHER'S NAME (First, Middle, Last) Harry Cantwell Day | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Elizabeth Robinson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Richard A. Day | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Chapel Ct. Walkersville, Maryland 21793 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount & Crematory | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL HOME LICENSEE <i>Dennis Stephen Xenakis</i> Dennis Stephen Xenakis | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Ischemic Cardiomyopathy</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>ASCVD</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive Heart Failure</i> <i>DTD</i> <i>Anorexia</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Davidson</i> | | | | 29c. LICENSE NUMBER D28987 | | 29d. DATE SIGNED (Month, Day, Year) 5-9-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5601 LOGG RAVEN BLVD BALTO MD 21239 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13216

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>James David Evans</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>5 8 90</i> | | 3. TIME OF DEATH <i>8:58 A M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>217-01-2091</i> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>80</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>10/6/1909</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>N. Carolina</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>Liberty Medical Center</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i> | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Baltimore City</i> | |
| 10c. CITY, TOWN OR LOCATION <i>Baltimore City</i> | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>2602 ROSLYN AVENUE</i> | |
| 10f. ZIP CODE <i>21216</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) <i>JOSEPH EVANS</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>PENNY EVANS</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>MILDRED EVANS</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2602 ROSLYN AVENUE BALTIMORE, MD 21216</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Arbutus Memorial Park</i> | | 20c. LOCATION — City or Town, State <i>Arbutus, Maryland</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| a. <i>Cardiopulmonary Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Chronic Obstructive Pulmonary Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregory S. Gordon</i> | | | | 29c. LICENSE NUMBER <i>D39269</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>5-8-90</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Gregory S. Gordon Liberty Medical Center</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 15 1990</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 4, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Ebaugh Katie</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>5-13-90</i> | | 3. TIME OF DEATH <i>12:55 A</i> | |
| 4. SOCIAL SECURITY NUMBER <i>213-01-4962</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>83</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>03-23-1907</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Virginia</i> | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Howard County General Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Columbia</i> | | 9c. COUNTY OF DEATH <i>Howard</i> | |
| 10a. STATE <i>Maryland</i> | | | | 10b. COUNTY <i>Howard</i> | | 10c. CITY, TOWN OR LOCATION <i>Ellicott City</i> | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER <i>5445 Kerger Road</i> | | | | 10f. ZIP CODE <i>21043</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Home</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Robert Hampson</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ella Catherine Henry</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Lucille E. Grogan</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5445 Kerger Road, Ellicott City, MD 21043</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Good Shepherd Cemetery</i> | | 20c. LOCATION — City or Town, State <i>Ellicott City, MD</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George E. MacNabb</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>MacNabb Funeral Home 301 Frederick Road, Balto., MD 21228</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Coronary heart failure</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Anemia</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER <i>022587</i> | | 29d. DATE SIGNED (Month/Day/Year) <i>5/15/90</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 15 1990</i> | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EDNA K. EXTER | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 14 90 | | 3. TIME OF DEATH 8:30 a.m. | |
| 4. SOCIAL SECURITY NUMBER 216-20-5372 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 90 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) DEC. 8 1899 | |
| 8. BIRTHPLACE (State or Foreign Country) MD. | | | | 9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH ----- | | | | 10a. STATE MD. | | 10b. COUNTY ----- | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3717 LYNDALE AVENUE | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) HENRY SCHULTZ | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print) THELMA FUHRMAN (NIECE) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3323 PUTTY HILL AVE., BALTO. MD. 21234 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Eugene J. Lastner Jr. | | | | 22. NAME AND ADDRESS OF FACILITY SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Baltimore, Md. 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Chronic Int. lung disease DUE TO (OR AS A CONSEQUENCE OF): Hypertension DUE TO (OR AS A CONSEQUENCE OF): Hypothyroidism Approximate Interval Between Onset and Death 1 day | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Wail Ann G.S.H. | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wail Ann G.S.H. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | | | | |
| 32. REGISTRAR'S SIGNATURE John L. ... | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary Walsh Ehler | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 12 90 | | 3. TIME OF DEATH 6:50 Am | |
| 4. SOCIAL SECURITY NUMBER 232-36-0044 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2/1/17 | |
| 9a. FACILITY NAME (If not institution, give street and number) John L. Deaton Hosp + Med. CTR. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO. CITY | | 9c. COUNTY OF DEATH | |
| 10a. STATE Md. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4711 Hampnett Avenue | | | | 10f. ZIP CODE 21214 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nursing Aide | | 16b. KIND OF BUSINESS/INDUSTRY Nursing Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles James Alkire | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Blanche Walsh | | | |
| 19a. INFORMANT'S NAME (Type/Print) Margaret Barnhart | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4711 Hampnett Avenue Baltimore, Md. 21214 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Queens Point May 14, 1990 | | 20c. LOCATION — City or Town, State Keyser, W. Va. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Gladden | | | | 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Inc. 5305 Harford Rd. 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Amyotrophic Lateral Sclerosis DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST } b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bradycardia, Hyponatremia, Chronic Obstructive Pulmonary Disease | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER J. Chambers | | | | 29c. LICENSE NUMBER D36141 | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAWFIK N. CHAMI, MD GREENSPRING STATION, LUTHERVILLE, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JANE (NMN) FLORIDO | | | | 2. DATE OF DEATH MONTH DAY YEAR May 10, 1990 | | 3. TIME OF DEATH 11:06 A.M. | | | |
| 4. SOCIAL SECURITY NUMBER 214-20-8658 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Mar. 27, 1910 | | | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) LELAND MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH Riverdale | | | |
| 9c. COUNTY OF DEATH Prince George | | | | 10a. STATE Maryland | | 10b. COUNTY Prince George | | | |
| 10c. CITY, TOWN OR LOCATION Riverdale | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 4800 Ravenswood Rd. | | | |
| 10f. ZIP CODE 20737 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) none | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Andrewicki | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Purdewski | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Katie E. Dombroski | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 Ravenswood Rd. Riverdale, MD. 20737 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Cemetery | | 20c. LOCATION — City or Town, State Glen Burnie, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Samuel B. [Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Singleton Funeral Home 1 Second Ave. S.W. Glen Burnie, MD. 21061 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. ASHD DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death < 2 hr. years | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) EX | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward E. Wilson M.D.</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ed Wilson M.D. | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13221

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last) FLORENCE FOWLES | | | | 2. DATE OF DEATH MONTH 05 DAY 14 YEAR 90 | | 3. TIME OF DEATH 1:00 AM | |
| 4. SOCIAL SECURITY NUMBER 220-20-8781 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03/02/07 | |
| 9a. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 22 S. Athol Avenue | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired | | 16b. KIND OF BUSINESS/INDUSTRY Chef Cook | | | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Olivia Jones | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1722 Appleton St. Balto., MD. 21217 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MT. Zion Cemetery | | 20c. LOCATION — City or Town, State Baltimore | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dorothy Hector #281 | | | | 22. NAME AND ADDRESS OF FACILITY E.L. Phillips F.H. 1721-27 N. Monroe | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. ARTERIO-SCLEROTIC HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. CHRONIC RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST URINARY TRACT INFECTION ANEMIA | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. URINARY TRACT INFECTION ANEMIA | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] MD. | | | | 29c. LICENSE NUMBER D 23300 | | 29d. DATE SIGNED (Month, Day, Year) 5-14-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BUDHIR, D. PATEL. 2600 D'ARCY RD. BALTO MD. 21215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

1955-01-01

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | REG. NO. | |
|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM L. FOUTS | | (OMAR) | | 2. DATE OF DEATH MONTH DAY YEAR MAY 13, 1990 | |
| 4. SOCIAL SECURITY NUMBER 214-38-0708 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 49 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) JULY 11, 1940 | | 8. BIRTHPLACE (State or Foreign Country) TENNESSEE | | 3. TIME OF DEATH 2:03 P.M. | |
| 9a. FACILITY NAME (If not institution, give street and number) FRANCIS SCOTT KEY HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE MARYLAND | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1021 QUANTRIL WAY | | 10f. ZIP CODE 21205 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MECHANIC | | 16b. KIND OF BUSINESS/INDUSTRY VENDING | | 17. FATHER'S NAME (First, Middle, Last) ROBERT A. FOUTS | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) THELMA PERRY | | 19a. INFORMANT'S NAME (Type/Print) CAROLYN FOUTS (WIFE) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1021 QUANTRIL WAY, BALTIMORE, MARYLAND 21205 | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) OAK LAWN CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Eugene J. Laitner</i> | | 22. NAME AND ADDRESS OF FACILITY SCHIMUNEK FUNERAL HOME, INC. 3331 BREHMS LANE, BALTIMORE, MARYLAND 21213 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardio Pulmonary Arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Ischemia ASCVD Hypertension | |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Morbid Obesity Tobacco Abuse | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | 29c. LICENSE NUMBER D-23607 | |
| 29d. DATE SIGNED (Month, Day, Year) 14 May 90 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HENRY SCAGLIOLA, M.D., 9712 BELAIR ROAD, BALTIMORE, MARYLAND 21236 | | 31. DATE FILED (Month, Day, Year) MAY 15 1990 | |
| 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | |

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90 13223

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lorraine Fenner | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH 0855 AM | |
| 4. SOCIAL SECURITY NUMBER unknown | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 55 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-30-34 | |
| 8. BIRTHPLACE (State or Foreign Country) New York | | | | 9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH none | | | | 10a. STATE Maryland | | 10b. COUNTY none | |
| 10c. CITY, TOWN OR LOCATION Baltimore City | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 2103 Homewood Avenue | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Negroid | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) unknown | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY none | |
| 17. FATHER'S NAME (First, Middle, Last) Cullen Harrison | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie | | | |
| 19a. INFORMANT'S NAME (Type/Print) Clayton Fenner | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2103 Homewood Ave, Balto, Md. 21218 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs</i> | | | | 22. NAME AND ADDRESS OF FACILITY Calvin B. Scruggs Funeral Home 1412 E. Preston Street, Balto, Md. 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Presumed Metastatic Breast Cancer | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Presumed LUNG METASTASIS; Bilateral Lung Infiltrates | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Probable mild Disseminated Intravascular Coagulation | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): due to Metastatic Disease | | | | | | | |
| Renal failure, Coagulopathy, anemia, hyponatremia due to cancer. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| first presented to hospital newly diagnosed left Breast cancer, hepatomegaly, jaundice & liver disease, Probable sepsis. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Sharon Y. Alongi | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHARON Y. ALONGI (Sharon Y. Alongi) Union Memorial Hosp | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEASED'S NAME (First, Middle, Last) Blanche L. FOX | | | | 2. DATE OF DEATH MONTH DAY YEAR May 10 1990 | | 3. TIME OF DEATH 4:20 PM | |
| 4. SOCIAL SECURITY NUMBER 236-16-9585A | | 5. SEX 1 M 2 XX | | 6. AGE (In yrs. last birthday) 95 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-4-1894 | |
| 8. BIRTHPLACE (State or Foreign Country) ILLINOIS | | 9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH ROSSVILLE | | 9c. COUNTY OF DEATH Baltimore County | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION ROSEDALE | | 10d. INSIDE CITY LIMITS? 1 YES 2 XX NO | |
| 10e. STREET AND NUMBER 8006 SAGAMORE ROAD | | | | 10f. ZIP CODE 21237 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 Never Married 2 Married XX Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XX NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES XX NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH GRADE College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOME MAKER | | 16b. KIND OF BUSINESS/INDUSTRY HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN W. MATHENY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MATTIE JARVIS | | | |
| 19a. INFORMANT'S NAME (Type/Print) ERMA MOELLMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5302 BANGERT STREET WHITE MARSH, MD 21162 | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 1006 CEMETERY 5-14-1990 | | 20c. LOCATION — City or Town, State SALEM, WEST VIRGINIA | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott P. Gardner | | | | 22. NAME AND ADDRESS OF FACILITY DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. Probable Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recent above knee amputation | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Paul Tecklenberg MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5-10-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Tecklenberg, M. D. #181 9000 Franklin Square Drive - 21237 | | | | | | | |
| 31. DATE (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ASSEN 29

90 13225

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William J. Fromm | | | | 2. DATE OF DEATH MONTH DAY YEAR May 10, 1990 | | 3. TIME OF DEATH 11:20A M | |
| 4. SOCIAL SECURITY NUMBER 210-09-0922 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-11-1909 | |
| 8. FACILITY NAME (If not institution, give street and number) Maryland General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH MARYLAND | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION DUNDALK | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1620 SEARLES ROAD | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COLLEGE (1-4 or 5+) N/A | | 16b. KIND OF BUSINESS/INDUSTRY BALTIMORE CITY PARKS | | 16c. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FOUNDATIONS CREW WORKER | |
| 17. FATHER'S NAME (First, Middle, Last) RAYMOND FROMM | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BLANCHE BURGMAN | | | |
| 19a. INFORMANT'S NAME (Type/Print) ESTELLE E. FROMM | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1620 SEARLES ROAD BALTIMORE, MARYLAND 21222 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH CEM. 5-14-1990 | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pulmonary Edema DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Anoxic Brain Damage DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Right hypernephroma; Status Post Right nephrectomy. | | | | | | | Approximate interval between Onset and Death |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. Kulaylat, MD (PG 41)</i> | | | | 29c. LICENSE NUMBER N/A | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Nuhad Kulaylat, M.D. c/o Maryland General Hospital | | | | | | | |
| 31. DATE SIGNED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13226

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>LEON R. GOODLAVAGE Sr.</u> | | | | 2. DATE OF DEATH MONTH <u>05</u> DAY <u>13</u> YEAR <u>90</u> | | 3. TIME OF DEATH <u>2:15A</u> M | |
| 4. SOCIAL SECURITY NUMBER <u>195 09 1400</u> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>73</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>10-28-16</u> | |
| 8. BIRTHPLACE (State or Foreign Country) <u>Pennsylvania</u> | | | | 9a. FACILITY NAME (If not institution, give street and number) <u>Harbor Hospital Center</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u> | |
| 9c. COUNTY OF DEATH <u>=====</u> | | | | | | | |
| 10a. STATE <u>Maryland</u> | | 10b. COUNTY <u>Anne Arundel</u> | | 10c. CITY, TOWN OR LOCATION <u>Linthicum</u> | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <u>201 Sweetser Road</u> | | | | 10f. ZIP CODE <u>21090</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9th Grade</u> College (1-4 or 5+) <u>Longshoreman</u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>I.L.A. Steamship Trade</u> | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Michael Goodlavage</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Frances Demski</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Pauline Goodlavage</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>201 Sweetser Road Linthicum, Maryland 21090</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Glen Haven Memorial Park</u> | | 20c. LOCATION — City or Town, State <u>Glen Burnie, Maryland</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Jerome Zmamiowski</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Acute Respiratory Failure</u> DUE TO (OR AS A CONSEQUENCE OF): a. <u>CHF</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Pulmonary Tuberculosis</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Massive Pulmonary fibrosis</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Septic Shock</u> DUE TO (OR AS A CONSEQUENCE OF): e. <u>S/p Total Abdominal Colectomy</u> DUE TO (OR AS A CONSEQUENCE OF): f. <u>Primary Bone Malignancy</u> | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>SEPTIC SHOCK</u> <u>S/p Total ABDOMINAL COLECTOMY</u> <u>PRIMARY BONE MALIGNANCY</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>M.B. Patel</u> HOUSE PHYSICIAN | | | | 29c. LICENSE NUMBER <u>HOUSE PHYSICIAN</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>5/13/90</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>M. B. PATEL MD 3001 S. HANOVER ST BALTIMORE MD 21230</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>MAY 15 1990</u> | | | | 32. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HELEN VIRGINIA GILLETTE | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 14, 1990 | | 3. TIME OF DEATH 0210 p.m. | |
| 4. SOCIAL SECURITY NUMBER 218-03-9663 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 12 1917 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE, MARYLAND | |
| 9c. COUNTY OF DEATH ANNE ARUNDEL | | | | 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION Glen Burnie | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 104 Country Club Drive | |
| 10f. ZIP CODE 21061 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) None | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | |
| 17. FATHER'S NAME (First, Middle, Last) Charles G. Boyd | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura O. Fogle | | | |
| 19a. INFORMANT'S NAME (Type/Print) Judith A. Martin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Georgia Ave. N.E., Glen Burnie, Md. 21061 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery | | 20c. LOCATION — City or Town, State Ft. Myer, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. George Hopkins</i> | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Severe Ischemic Cardiomyopathy.</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Cardiogenic Shock.</i> <i>Ventricular Tachycardia.</i> <i>Pulmonary edema.</i> | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pneumothorax</i> <i>Complete Heart Block.</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Ramirez</i> | | | | 29c. LICENSE NUMBER P36256 | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JORGE M. RAMIREZ, M.D. 7845 OAKWOOD ROAD #205 GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13228

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIS GRENADÉ | | | | 2. DATE OF DEATH MONTH 05 DAY 10 YEAR 90 | | 3. TIME OF DEATH 0120 M | |
| 4. SOCIAL SECURITY NUMBER 214-68-0325 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 31 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6/5/58 | |
| 8. BIRTHPLACE (State or Foreign Country) Balto., MD | | | | 9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH Maryland | | | | 10. RESIDENCE OF DECEDENT | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2507 ELLSINORE AVENUE | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IE YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES SCOTT, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY LEE | | | |
| 19a. INFORMANT'S NAME (Type/Print) ALAN WILLIS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2507 ELLSINORE AVE BALTIMORE, MD 21216 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i> | | | | 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARYSTOLE DUE TO (OR AS A CONSEQUENCE OF): b. PC Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. HIV 1 DUE TO (OR AS A CONSEQUENCE OF): d. 2 INFERIOR MI Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Resident</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) SALVATORE JOSEPH GEPPI | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 212-03-8292 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-6-06 | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Joseph Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 405 Hopkins Road | | | | 10f. ZIP CODE 21212 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner | | 16b. KIND OF BUSINESS/INDUSTRY Produce | | | |
| 17. FATHER'S NAME (First, Middle, Last) Anthony Geppi | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Battaglia | | | |
| 19a. INFORMANT'S NAME (Type/Print) Carroll A. Geppi | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9507 Gun Hill Circle Perry Hall Maryland 21236 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens | | 20c. LOCATION — City or Town, State Lutherville, Maryland | | | |
| 21. SIGNATURE OF FUNERAL HOME Dennis Stephen Xenakis | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER William M. Smith M.D. | | | | 29c. LICENSE NUMBER D10809 | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ↑ SAME AS ABOVE 1900 E. No. 1st St. BALTO MD 21239 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Diana L. Gray | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-9-90 | | 3. TIME OF DEATH 8:35PM M | |
| 4. SOCIAL SECURITY NUMBER 215-64-8169 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 35 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5 24 54 | |
| 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1813 Dundalk Avenue | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th College (1-4 or 5+) College | | | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) William Wiedefeld | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Patricia Poswiatowsky | | | |
| 19a. INFORMANT'S NAME (Type/Print) Richard F. Gray | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1813 Dundalk Avenue - Baltimore, Md. 21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 5/14/90-Meadowridge Cemetery | | 20c. LOCATION — City or Town, State Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Walter Dabrowski | | | | 22. NAME AND ADDRESS OF FACILITY Walter Dabrowski Funeral Chapel 1005 Dundalk Avenue - Baltimore, Md. 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: In the course of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Julia C. Goodin, MD | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-10-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julia C. Goodin, MD 111 Penn Street, Baltimore, MD 21201 VC | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE Julia Davidson | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) DOROTHY B. GROSS | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 09 1990 | | 3. TIME OF DEATH 05:09 P M | |
| 4. SOCIAL SECURITY NUMBER 213 18 3863 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 07 11 1908 | |
| 9a. FACILITY NAME (If not institution, give street and number) G.B.M.C.-6701 N. CHARLES STREET | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, MD 21204 | | 9c. COUNTY OF DEATH BALTIMORE COUNTY | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE - PARKVILLE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2908 KINGS RIDGE RD APT D. | | | | 10f. ZIP CODE 21234 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERK | | 16b. KIND OF BUSINESS/INDUSTRY DRUG | | | |
| 17. FATHER'S NAME (First, Middle, Last) GEORGE S. LOPEZ | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) HATTIE DRURY | | | |
| 19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY | | 20c. LOCATION — City or Town, State PARKVILLE MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE D. Evans | | | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. RESPIRATORY FAILURE/CARDIAC FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M. H. Stinson M.D. | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) MAY 11, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. H. Stinson 120 S. State St. Baltimore, Md. 21201 | | | | | | | |
| 31. DATE OF DEATH (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BLANCHE E. GOLDSMITH | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 9, 1990 | | 3. TIME OF DEATH 3:10 A.M. | |
| 4. SOCIAL SECURITY NUMBER 217-36-5365 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 49 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) SEPT. 7, 1940 | |
| 8. BIRTHPLACE (State or Foreign Country) WASHINGTON D.C. | | 9a. FACILITY NAME (If not institution, give street and number) 8811 BAKER AVE 21234 | | 9b. CITY, TOWN OR LOCATION OF DEATH PARKVILLE | | 9c. COUNTY OF DEATH BALTO, CO. | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY BALTO. CO. | | 10c. CITY, TOWN OR LOCATION ESSEX | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 500 SOUTH MARLYN AVE | | 10f. ZIP CODE 21221 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (13-16 or 17+) - | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) GEORGE RICHARD KING | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET LOUISE MULLIGAN | | | |
| 19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GREENMOUNT CEM. | | 20c. LOCATION — City or Town, State BALTO, CITY, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeffrey L. Fair | | | | 22. NAME AND ADDRESS OF FACILITY EVANS FUNERAL CHAPEL | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. GAMMOPATHY DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. lymphoma DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| Approximate Interval Between Onset and Death 1 week 1 month 10 years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ken Pienta MD | | | | 29c. LICENSE NUMBER 036665 | | 29d. DATE SIGNED (Month, Day, Year) 05/09/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KEN PIENTA JOHNS HOPKINS HOSP. BALTO. MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Gwendolyn Holley | | | | 2. DATE OF DEATH MONTH 05 DAY 12 YEAR 90 | | 3. TIME OF DEATH 9:43 P.M. | |
| 4. SOCIAL SECURITY NUMBER 217-50-0577 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 39 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 08-08-50 | |
| 8. BIRTHPLACE (State or Foreign Country) California | | | | 9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson, MD | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Md. | | 10b. COUNTY Balto. | |
| 10c. CITY, TOWN OR LOCATION Balto. | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2108 Louise Avenue | |
| 10f. ZIP CODE 21214 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) John A. Parker, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Beatrice Johnson | | | |
| 19a. INFORMANT'S NAME (Type/Print) John A. Parker, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2108 Louise Ave., Balto., Md. 21214 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Mem. Pk. | | | |
| 20c. LOCATION — City or Town, State Arbutus, Md. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Hala March | | | |
| 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Ave. | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acquired Immune Deficiency Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Carla S. Alexander | | | |
| 29c. LICENSE NUMBER D 27087 | | | | 29d. DATE SIGNED (Month, Day, Year) 05-12-90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carla S. Alexander, M.D.—Stella Maris Hospice-Dulaney Valley Rd. — Towson 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REG. NO.

DHMH-16 Rev 1/89

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) PATRICIA A. HORCHAR | | | | 2. DATE OF DEATH MONTH 5 , YEAR 1990 | | | | 3. TIME OF DEATH 3:30 A | | | | | |
| 4. SOCIAL SECURITY NUMBER 218-42-2022 | | | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 45 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) FEB. 4, 1945 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. JOSEPH'S HOSPITAL | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | | | 9c. COUNTY OF DEATH BALTIMORE | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY BALTIMORE | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 9000 PERRYVALE ROAD | | | | | | 10f. ZIP CODE 21236 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SENIOR ACCOUNTANT REP. | | | | 16b. KIND OF BUSINESS/INDUSTRY BANK | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) ALBERT J. HARDESTY | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIAN WHITE | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) JOSEPH W. HORCHAR (HUSBAND) | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9000 PERRYVALE ROAD, BALTIMORE, MARYLAND 21236 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK | | | | 20c. LOCATION — City or Town, State MARYLAND | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Eugene J. Leston</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD, BALTIMORE, MARYLAND 21236 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARCINOMA OF THE BREAST WITH | | | | | | | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): CEREBRAL, BONE & LUNG - METASTASIS | | | | | | | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ceballos MD</i> | | | | 29c. LICENSE NUMBER D 25886 | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CEBALLOS, M.D. - ST. JOSEPH HOSPITAL - TOWSON, MD 21204 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Norman C. Huff Jr.</u> | | | | 2. DATE OF DEATH MONTH <u>May</u> DAY <u>9</u> YEAR <u>1990</u> | | 3. TIME OF DEATH <u>848</u> <u>P</u> | |
| 4. SOCIAL SECURITY NUMBER <u>160-46-1795</u> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>36</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>5-22-53</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Suburban Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Bethesda</u> | | 9c. COUNTY OF DEATH <u>Montgomery</u> | |
| 10a. STATE <u>MD</u> | | | | 10b. COUNTY <u>Montgomery</u> | | 10c. CITY, TOWN OR LOCATION <u>Rockville</u> | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER <u>409 1/2 Baltimore Road</u> | | | | 10f. ZIP CODE <u>20850</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Computer Technician</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>Data Works</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Norman C. Huff, Sr.</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Anna B. Kelley</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Norman C. Huff, Sr.</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Rt. 1 Box 26 Tarentum, PA 15084</u> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Greenwood Memorial Park</u> | | 20c. LOCATION — City or Town, State <u>Lower Burrell, PA</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Ives-Pearson Funeral Homes</u> <u>2847 Wilson Blvd. Arlington, VA 22201</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pneumocystis Pneumonia</u> | | | | | | | <u>4 months</u> |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. <u>Acquired immuno-deficiency syndrome</u> | | | | | | | <u>unknown</u> |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. <u></u> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. <u></u> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA | | OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u> | | 29c. LICENSE NUMBER <u>D01193</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>5-10-90</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>MAY 15 1990</u> | | | | | | | |
| 32. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Anna Marian Holland | | | | 2. DATE OF DEATH MONTH DAY YEAR May 13, 1990 | | 3. TIME OF DEATH 10:30 AM | |
| 4. SOCIAL SECURITY NUMBER 218 01 8877 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 18, 1910 | |
| 9a. FACILITY NAME (If not institution, give street and number) 6803 Bank Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Balto. City | |
| 10a. STATE Maryland | | | | 10b. COUNTY Balto. City | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 6803 Bank Street | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 years | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales | | 16b. KIND OF BUSINESS/INDUSTRY Bakery | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Capperella | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Metrangle | | | |
| 19a. INFORMANT'S NAME (Type/Print) Rose Picco | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 446 W. 23rd Street Baltimore, Maryland 21211 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lakeview Memorial Park | | 20c. LOCATION — City or Town, State Eldersburg, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE B. C. Veneracion | | | | 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road, Baltimore, Maryland 21211 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. A.S. C.V.D. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 1 day years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER B. C. Veneracion M.D. | | | | 29c. LICENSE NUMBER D13664 | | 29d. DATE SIGNED (Month, Day, Year) 5/13/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B. C. VENERACION JR M.D. 1576 Merriott Blvd Suite 200 Baltimore MD 21202 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Catherine Diergart Nause | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 9 90 | | 3. TIME OF DEATH 1:30 P.M. | |
| 4. SOCIAL SECURITY NUMBER 215-28-4080 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 04/25/33 | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. JOSEPH Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH 7600 York Rd Towson Baltimore | | 9c. COUNTY OF DEATH MD | |
| 10a. STATE MD | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION Green Arm | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4216 Honor View Rd | | | | 10f. ZIP CODE 21057 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) AT Home | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) HENRY DIEGERT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CLARA M. KIMBALL | | | |
| 19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CEMETERY | | 20c. LOCATION — City or Town, State BALTO., MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8300 HARFORD ROAD - PARKVILLE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → metastatic carcinoma, probably ovarian Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death not known |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Natividad D. de Leon, M.D. | | | | 29c. LICENSE NUMBER 019508 | | 29d. DATE SIGNED (Month, Day, Year) 5/9/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NATIVIDAD D. DE LEON, C/O ST. JOSEPH HOSPITAL, TOWSON, MD., 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Fannie M. Johnson | | | | 2. DATE OF DEATH MONTH 05 DAY 06 YEAR 90 | | 3. TIME OF DEATH 11 05 M | |
| 4. SOCIAL SECURITY NUMBER 215-12-5845 | | 6. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3 13 24 | |
| 9a. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| 10a. STATE MD | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2345 DRUID HILL AVE | | 10f. ZIP CODE 21217 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NURSE ASS'T | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) ARNOLD WEBSTER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EMMA FISHER | | | |
| 19a. INFORMANT'S NAME (Type/Print) BETTY THAMES | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2565 CECIL AVE BALTIMORE, MD 21218 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) TABERNACLE U.M. Church Cemetery, Baltimore, MD | | | |
| 20c. LOCATION — City or Town, State Baltimore, MD | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Derry Harris | | | |
| 22. NAME AND ADDRESS OF FACILITY CHATMAN-HARRIS F.H. BALTIMORE, MD | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute renal failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Hypertension c. Coronary artery disease d. Cardiopulm arrest | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 5/7/90 | | | |
| 28b. TIME OF INJURY M | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER D30115 | | | |
| 29d. DATE SIGNED (Month, Day, Year) 5/7/90 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T. Ohoppemai, MD 2800 Liberty Hgts Av Balt MD 21215 | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Edward T. Johnson | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-10-90 | | 3. TIME OF DEATH P 9:56 | |
| 4. SOCIAL SECURITY NUMBER 705123775 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-9-02 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) ST. Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON, MD. | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE MARYLAND | | | |
| 10b. COUNTY BALTIMORE | | | | 10c. CITY, TOWN OR LOCATION PARKVILLE | | | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 9300 SHAOY CREEK WAY | | | |
| 10f. ZIP CODE 21234 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONDUCTOR | | 16b. KIND OF BUSINESS/INDUSTRY B.T.O. RAIL ROAD | | | |
| 17. FATHER'S NAME (First, Middle, Last) Winfield S. Johnson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY STAFFORD | | | |
| 19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) DUBLAND VALLEY | | 20c. LOCATION — City or Town, State TIMONUM, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Don J. Evans | | | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. MYOCARDIAL INFARCTION WITH | | | | | | | |
| b. HEART FAILURE | | | | | | | |
| c. SEPSIS | | | | | | | |
| d. PERIPHERAL VASCULAR DISEASE. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ceballos, MD | | | | 29c. LICENSE NUMBER D 25886 | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CEBALLOS, M. D. - ST. JOSEPH HOSPITAL - TOWSON, MD 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Samuel Johnson | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 14 90 | | 3. TIME OF DEATH 0540A | |
| 4. SOCIAL SECURITY NUMBER 212 09 0151 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-31-04 | |
| 8. BIRTHPLACE (State or Foreign Country) MD | | | | 9a. FACILITY NAME (If not institution, give street and number) Liberty Med. Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Balto. | |
| 9c. COUNTY OF DEATH MD | | | | 10a. STATE MD | | 10b. COUNTY Balto | |
| 10c. CITY, TOWN OR LOCATION Balto | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER Belden Jack Nursing | |
| 10f. ZIP CODE 21217 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Henry Johnson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Treasol | | | |
| 19a. INFORMANT'S NAME (Type, Print) Margaret C. Johnson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2225 Aiken St | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MT. CALVARY Cem | | 20c. LOCATION — City & Town, State A.A. County MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph B. Locke | | | | 22. NAME AND ADDRESS OF FACILITY Locke Funeral Home 1304 N. Central A. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Right sided pneumonia Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Lymphoma DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Gregory S. Gordon MD | | | | 29c. LICENSE NUMBER 759269 | | 29d. DATE SIGNED (Month, Day, Year) 5-14-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gregory S. Gordon MD Liberty Medical Center | | | | | | | |
| 31. DATE FILLED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE John A. ... | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Continued on page 14562

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | |
|--|----------------------------------|--|--|---|--|--|--|---|---|--|----|----------------------------------|----|----------------------------------|----|----------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last) THOMAS KOTCHEN | | | | 2. DATE OF DEATH MONTH 05 DAY 13 YEAR 90 | | | | 3. TIME OF DEATH 2050 M | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 220 20 4561 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 61 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7-3-1928 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | | | 9c. COUNTY OF DEATH ===== | | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY ===== | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | |
| 10e. STREET AND NUMBER 5101 Pennington Avenue | | | | 10f. ZIP CODE 21226 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean Conflict | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Operating Engineer | | 16b. KIND OF BUSINESS/INDUSTRY Construction | | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Steven Kotchen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Zivchuck | | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) John Kotchen | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10815 Lakespring Way Cockeysville, Md. 21030 | | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>C. Richard L. Jones</i> | | | | 22. NAME AND ADDRESS OF FACILITY George J. Gonc Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="0"> <tr> <td>a.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> </tr> <tr> <td>c.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> </tr> <tr> <td>d.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> </tr> </table> SEPSIS CONGESTIVE HEART FAILURE PROBABLE PNEUMONIA | | | | | | | | a. | DUE TO (OR AS A CONSEQUENCE OF): | Approximate Interval Between Onset and Death | b. | DUE TO (OR AS A CONSEQUENCE OF): | c. | DUE TO (OR AS A CONSEQUENCE OF): | d. | DUE TO (OR AS A CONSEQUENCE OF): |
| a. | DUE TO (OR AS A CONSEQUENCE OF): | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | |
| b. | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| c. | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| d. | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. WBC ↑ 17 | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify): | | | | | | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert J. Small</i> | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/13/90 | | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARBOR HOSP CTR BALT MD | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

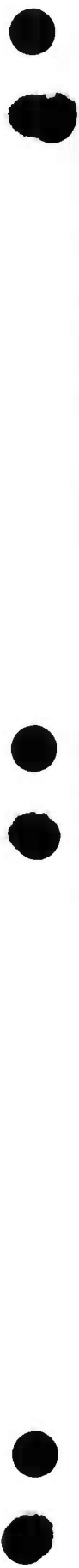
DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Jason Wayne Kinniburgh | | | | 2. DATE OF DEATH MONTH DAY YEAR May 11, 1990 | | 3. TIME OF DEATH 9:00pm M | |
| 4. SOCIAL SECURITY NUMBER 544-96-8072 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 24 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 02-26-1966 | | 8. BIRTHPLACE (State or Foreign Country) Idaho | |
| 9a. FACILITY NAME (If not institution, give street and number) 619 Jasper Street 21201 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH ----- | |
| 10a. STATE Maryland | | 10b. COUNTY ----- | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 619 Jasper Street | | | | 10f. ZIP CODE 21201 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No-- If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE -- American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waiter | | 16b. KIND OF BUSINESS/INDUSTRY Restaurant | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Allen Kinniburgh | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sylvia Marguerite Herman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Peter R. Kutscha | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 Jasper Street, Balto., MD 21201 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | 20c. LOCATION -- City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb | | | | 22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland 299 Frederick Road, Balto., MD 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Disseminated Kaposi's Sarcoma DUE TO (OR AS A CONSEQUENCE OF): b. AIDS DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Disseminated MAI | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY -- At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Samuel J. Westrick MD | | | | 29c. LICENSE NUMBER D28625 | | 29d. DATE SIGNED (Month, Day, Year) 5-12-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Samuel J. Westrick, M. D., 3100 St. Paul Street, Balto., MD 21218 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Catherine A. Kunz | | | | 2. DATE OF DEATH MONTH DAY YEAR May 10 1990 | | 3. TIME OF DEATH 9:10 P.M. | |
| 4. SOCIAL SECURITY NUMBER 216-46-2681 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 15 1913 | |
| 8. BIRTHPLACE (State or Foreign Country) New Jersey | | | | 9a. FACILITY NAME (If not institution, give street and number) St. Joseph's Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Glen Arm | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 11630 Glen Arm Road - Notch Cliff | |
| 10f. ZIP CODE 21057 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Homemaking | |
| 17. FATHER'S NAME (First, Middle, Last) Francis McKernan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Lubanty | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joan C. McDermott | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 Rickwood Rd., Timonium, Md. 21093 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mausoleum | | 20c. LOCATION — City or Town, State Timonium, Md. 21093 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin D. Lawson | | | | 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld Timonium, Maryland 21093 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septic Peritonitis Due to (or as a consequence of): Perforated bowel. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Carcinomatosis. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Carcinomatosis. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Armando A. Real, M.D. / SURGICAL HOUSE OFFICER | | | | 29c. LICENSE NUMBER D-24710 | | 29d. DATE SIGNED (Month, Day, Year) 5-10-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ARMANDO A REAL, M.D. / C/O - ST. JOSEPH HOSP. TOWSON, MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ANNE D. KLEIN | | 2. DATE OF DEATH MONTH 5 DAY 6 YEAR 90 | | 3. TIME OF DEATH 10:30 P.M. | |
| 4. SOCIAL SECURITY NUMBER 577 34 5960 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs., last birthday) 90 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) May 9, 1899 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Hebrew Home of Greater Washington | | 9b. CITY, TOWN OR LOCATION OF DEATH Rockville | | 9c. COUNTY OF DEATH MONTGOMERY | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Rockville | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 6121 Montrose Road | | 10f. ZIP CODE 20852 | |
| 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 8 years | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | |
| 17. FATHER'S NAME (First, Middle, Last) Louis Sachs | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Miller | | | |
| 19a. INFORMANT'S NAME (Type/Print) Henry Jason Klein | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3714 Nimitz Road, Kensington, Maryland 20895 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cemetery — City or Town, State Ohev Sholom Talmud Torah Congregation Washington, DC | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald M. Stein</i> | | 22. NAME AND ADDRESS OF FACILITY DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CHRONIC HEART FAILURE Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. ISCHEMIC CARDIOMYOPATHY c. SQUAMOUS CELL CARCINOMA INVADING RIGHT ORBIT | | | | | Approximate Interval Between Onset and Death MANY YRS |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SQUAMOUS CELL CARCINOMA INVADING RIGHT ORBIT | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>D.D. Patel</i> STAFF PHYSICIAN | | 29c. LICENSE NUMBER D 18084 | | 29d. DATE SIGNED (Month, Day, Year) 5/7/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852 | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE <i>J. Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) David B. Kiel | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-10-90 | | 3. TIME OF DEATH 7:23AM M | |
| 4. SOCIAL SECURITY NUMBER 212 58 6028 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 39 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) SEPT. 21 1950 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4619 CHATFORD AVE. | | 10f. ZIP CODE 21206 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SELF EMP. | | 16b. KIND OF BUSINESS/INDUSTRY PLUMMER | | | |
| 17. FATHER'S NAME (First, Middle, Last) FREDERICK S. KIEL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CHARLOTTE L. SHAW | | | |
| 19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH | | 20c. LOCATION — City or Town, State ROSELAND, MO. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] Julia C. Goodin, MD | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-10-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julia C. Goodin, MD 111 Penn Street, Baltimore, MD 21201 | | | | | | | |
| 31. DATE (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | CERTIFICATE OF DEATH | | REG. NO. | |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT L. KOLSCHER | | | | 2. DATE OF DEATH MONTH 5 DAY 13 YEAR 90 | | 3. TIME OF DEATH 7:19 A M | |
| 4. SOCIAL SECURITY NUMBER 217-20-2269 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6 11 27 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | 9a. FACILITY NAME (If not institution, give street and number) SINAI Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore MD. | | 9c. COUNTY OF DEATH | |
| 10a. STREET AND NUMBER 12 Hickory Meadow Road | | | | 10f. ZIP CODE 21030 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS College (1-4 or 5+) 4 YRS | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SELF EMP | | 16b. KIND OF BUSINESS/INDUSTRY REAL ESTATE AGENT | | | |
| 17. FATHER'S NAME (First, Middle, Last) ELMER LOUIS KOLSCHER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) IRMA E. WENTWORTH | | | |
| 19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNTAIN CEMETERY | | 20c. LOCATION — City or Town, State BALTO, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF CHIMES 2325 YORK ROAD - TIMONIUM | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cirrhotic Liver Disease Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Coronary Artery Disease a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER 9310 | | 29d. DATE SIGNED (Month, Day, Year) 5-13-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARC ESPOSITO SINAI Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 5-12-90

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JESSE FRANK KINGSBOROUGH <i>Jessie Frank Kingsborough</i> | | | | 2. DATE OF DEATH MONTH 5 DAY 12 YEAR 90 | | 3. TIME OF DEATH 2:15 AM | |
| 4. SOCIAL SECURITY NUMBER 218-44-8289 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 42 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6/5/47 | |
| 9a. FACILITY NAME (If not institution, give street and number) Deaton Hospital & Medical Center Baltimore | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH City | |
| 10a. STATE Maryland | | 10b. COUNTY none | | 10c. CITY, TOWN OR LOCATION Baltimore City | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 810 N. Washington Street | | | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 6-10-66 to 6-09-69 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: X | | 14. RACE — American Indian, Black, White, etc. Specify: Negroid | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) none | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer | | 16b. KIND OF BUSINESS/INDUSTRY Paint Factory | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Earl Kingsborough | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Thelma Gilliam | | | |
| 19a. INFORMANT'S NAME (Type/Print) Thelma Kingsborough | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 Washington Street, Balto, Md. 21205 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Veterans | | 20c. LOCATION — City or Town, State Owingsmills, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs</i> | | | | 22. NAME AND ADDRESS OF FACILITY Calvin B. Scruggs Funeral Home 1412 E. Preston Street Baltimore, Md. 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SQUAMOUS CELL CANCER OF THROAT Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. TOBACCO ABUSE c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death 2 YEARS YEARS | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1. <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 5. <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>James P. Richardson MD</i> | | 29c. LICENSE NUMBER 027394 | | 29d. DATE SIGNED (Month, Day, Year) 5/4/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 611 S. CHARLES ST. BALTIMORE, MD 21235 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 12500

The first of these is the fact that the

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) MABEL R. KAUFMAN | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 12, 1990 | | 3. TIME OF DEATH 6:00 A M | |
| 4. SOCIAL SECURITY NUMBER 218-09-5347 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) NOV. 27, 1911 | |
| 9a. FACILITY NAME (If not institution, give street and number) 356 BIGLEY AVE. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH LANSDOWNE | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION LANSDOWNE | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 356 BIGLEY AVE. | | | |
| 10f. ZIP CODE 21227 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TELEPHONE OPERATOR | | 16b. KIND OF BUSINESS/INDUSTRY C&P TELEPHONE CO. | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN HUNT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edith Bailey | | | |
| 19a. INFORMANT'S NAME (Type/Print) MABEL GLATTHAAR | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 356 BIGLEY AVE. BALTIMORE MD. 21227 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH MAY 15, 1990 | | 20c. LOCATION — City or Town, State ROSSVILLE MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Gladden | | | | 22. NAME AND ADDRESS OF FACILITY BALTIMORE MD. 21214 LEONARD J. RUCK INC. 5305 HARFORD RD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Possible Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): HASCD Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): COPD | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 9 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 10 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER A. Shokk |
| 29c. LICENSE NUMBER A 23530 | | | | | | | 29d. DATE SIGNED (Month, Day, Year) 5-12-90 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ASHOK K CHATTERJEE MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Catherine K. Krimm | | | | 2. DATE OF DEATH MONTH DAY YEAR May 9, 1990 | | 3. TIME OF DEATH 10:50 A. M | |
| 4. SOCIAL SECURITY NUMBER 705-10-5049 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 27, 1905 | |
| 9a. FACILITY NAME (If not institution, give street and number) Dulaney Towson Nursing Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Hydes | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 4513 Hydes Road | | 10f. ZIP CODE 21082 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S. A. | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 4 | |
| 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Legal Secretary | | | | 16b. KIND OF BUSINESS/INDUSTRY Western Maryland Railway | | 17. FATHER'S NAME (First, Middle, Last) Frank Kues | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Wambach | | | | 19a. INFORMANT'S NAME (Type/Print) Denis Krimm | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same As #10 | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gds. 5-11-90 | | 20c. LOCATION — City or Town, State Timonium, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mary R. DiMarzio | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death 41 days 5+ yrs. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Charles F. O'Donnell M.D. | | | | 29c. LICENSE NUMBER D-09383 | | 29d. DATE SIGNED (Month, Day, Year) May 10, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles F. O'Donnell M.D. 7501 York Road, Towson, Md. 21204 | | | | | | | |
| 31. DATE FILLED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Samuel Earl LaFrank | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-11-90 | | 3. TIME OF DEATH 1:00AM M | |
| 4. SOCIAL SECURITY NUMBER 343-40-5911 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 39 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 10, 1951 | |
| 8. BIRTHPLACE (State or Foreign Country) Illinois | | | | 9a. FACILITY NAME (If not institution, give street and number) Warren Road at Ridgeland | | 9b. CITY, TOWN OR LOCATION OF DEATH Cockeysville | |
| 9c. COUNTY OF DEATH Baltimore County | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Cockeysville | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 21 Dulaney Hills Court | | | | 10f. ZIP CODE 21030 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 6+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Director of Distribution | | 16b. KIND OF BUSINESS/INDUSTRY Noxell | | | |
| 17. FATHER'S NAME (First, Middle, Last) Peter John LaFrank | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Loretta Catherine Blank | | | |
| 19a. INFORMANT'S NAME (Type/Print) Annette M. LaFrank | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10e. | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. John's Cemetery | | 20c. LOCATION — City or Town, State Collinsville, Illinois | | | |
| 21. SIGNATURE OF INFORMANT Bryan W. Clary | | 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld Timonium, Maryland 21093 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Scene | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 5-11-90 | | 28b. TIME OF INJURY 12:50AM | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED Driver in auto/fixed object/ ejected | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Road | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Warren Road/Ridgeland, Balto. Co. Maryland | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Mario F. Golle, Jr., MD | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-11-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mario F. Golle, Jr., MD 111 Penn Street, Baltimore, MD 21201 vc | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE John L. ... | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) BLANCHE LUFTIG | | | | 2. DATE OF DEATH MONTH DAY YEAR May 9 1990 | | 3. TIME OF DEATH 7:50 A. M | |
| 4. SOCIAL SECURITY NUMBER 578 46 0895 D | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 12, 1902 | |
| 9a. FACILITY NAME (If not institution, give street and number) Kensington Gardens Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Kensington | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Silver Spring | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 10110 New Hampshire Avenue | | | |
| 10f. ZIP CODE 20903 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Hyman Stanger | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jeannette (unascertainable) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Jeanette G. Polansky | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6703 Adelphi Road, University Park, Maryland 20782 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Keshet Israel Congregation Cemetery | | 20c. LOCATION — City or Town, State Washington, D. C. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald M. Stein</i> | | | | 22. NAME AND ADDRESS OF FACILITY DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D. C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardio-Pulmonary Arrest</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Atherosclerotic Cardiovascular Disease</i> b. <i>Due to (or as a consequence of):</i> c. <i>Due to (or as a consequence of):</i> d. <i>Due to (or as a consequence of):</i> | | | | | | | Approximate interval Between Onset and Death <i>10 min</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Morton Altschuler M.D.</i> | | | | 29c. LICENSE NUMBER D00232 | | 29d. DATE SIGNED (Month, Day, Year) 5-9-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Morton Altschuler, M. D., 1299 Lamberton Drive, Silver Spring, Maryland 20902 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of" are visible.]

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES H. LEWIS | | | | 2. DATE OF DEATH MONTH DAY YEAR May 7, 1990 | | 3. TIME OF DEATH 10:20 a m | |
| 4. SOCIAL SECURITY NUMBER 235-16-9007 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan 5, 1919 | |
| 9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | | 9c. COUNTY OF DEATH Allegany | |
| 10a. STATE WV | | | | 10b. COUNTY Mineral | | 10c. CITY, TOWN OR LOCATION Keyser | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 311 Newton Street | | | | 10f. ZIP CODE 26726 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Building Contractor | | 16b. KIND OF BUSINESS/INDUSTRY Self | | | |
| 17. FATHER'S NAME (First, Middle, Last) Adam S. Lewis | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Rumer | | | |
| 19a. INFORMANT'S NAME (Type/Print) Margaret Lewis | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 Newton Street Keyser, WV 26726 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Duling Cemetery | | 20c. LOCATION — City or Town, State Keyser, WV 26726 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alvin Rumer</i> | | | | 22. NAME AND ADDRESS OF FACILITY Rotruck Funeral Home 85 South Main Street Keyser, WV 26726 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC ARREST. Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Ischemic Cardiomyopathy PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure, H. Vent. fibrillation | | | | | | | Approximate Interval Between Onset and Death |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ranjithan MD</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/8/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. N. Ranjithan, Memorial Hospital Medical Building, Cumberland, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Gordon</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2015-10-02

90 13254

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CARMEL MICHAEL LONGO | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 12 90 | | 3. TIME OF DEATH 2:10A M | |
| 4. SOCIAL SECURITY NUMBER 203 01 1908 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) SEPT. 30 1921 | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. JOSEPH HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION PARKVILLE | |
| 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | 10e. STREET AND NUMBER 7814 WESTMORELAND AVE | | | |
| 10f. ZIP CODE 21234 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES W.W.II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 YRS | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SELF EMP | | 16b. KIND OF BUSINESS/INDUSTRY GARAGE OWNER | | | |
| 17. FATHER'S NAME (First, Middle, Last) SAMUEL S. LONGO | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) JENNIE MORRISON | | | |
| 19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE | | | |
| 20a. METHOD OF DISPOSITION 1 BURIAL 2 CREMATION 3 REMOVAL FROM STATE 4 DONATION 5 OTHER (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH | | 20c. LOCATION — City or Town, State ROSEDALE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. END STAGE CARDIOMYOPATHY DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA | | 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 YES 2 NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER D33215 | | 29d. DATE SIGNED (Month, Day, Year) 05/12/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEM:19a per FH G-663
5-22-90 cm

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FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LORENCE M. MORSE | | | | 2. DATE OF DEATH MONTH 5 DAY 10 YEAR 90 | | 3. TIME OF DEATH 6 53A M | |
| 4. SOCIAL SECURITY NUMBER 215-32-2308 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/25/20 | |
| 9a. FACILITY NAME (If not institution, give street and number) Sinai Hosp. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Balto. | | 9c. COUNTY OF DEATH | |
| 10a. STATE MD | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Balto. | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 4006 Ayrdale Ave. | | 10f. ZIP CODE 21215 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | |
| 16b. KIND OF BUSINESS/INDUSTRY Western Md. Collage | | | | 17. FATHER'S NAME (First, Middle, Last) Oliver Morse | | | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hanna Powell | | | | 19a. INFORMANT'S NAME (Type/Print) Martha Costley COSTLEY | | | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4006 Ayrdale Ave., Balto., Md. 21215 | | | | 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | |
| 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cem. | | | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Walter Edmond | | | | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → septic shock. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Staph. aureus sepsis. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CRF | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Anupa Khastgir M.D. / written by Hassan-Gheza (M.D.) | |
| 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANUPA KHAISTGIR Sinai Hospital of Baltimore | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE Gina Davidson-Randall | | | | | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Margaret N. Muthiora | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-2-90 | | 3. TIME OF DEATH 5:10PM M | |
| 4. SOCIAL SECURITY NUMBER 220-88-6375 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 24 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-06-65 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington DC | | 9a. FACILITY NAME (If not institution, give street and number) Peninsula General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Salisbury | | 9c. COUNTY OF DEATH Wicomico County | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Howard | | 10c. CITY, TOWN OR LOCATION Columbia | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5053 Hesperus Drive | | | | 10f. ZIP CODE 21044 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) None College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) None | | 16b. KIND OF BUSINESS/INDUSTRY None | | | |
| 17. FATHER'S NAME (First, Middle, Last) Johnstone Muthiora | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Barbara A. Schremp | | | |
| 19a. INFORMANT'S NAME (Type/Print) Barbara A. Muchene | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5053 Hesperus Drive, Columbia, MD 21044 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb | | | | 22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland 299 Frederick Road, Balto., MD 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia in association with severe mental retardation (clinical) | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER James Kaplan, MD | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-4-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James Kaplan, MD 111 Penn Street, Baltimore, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

10342260-01P
MILLER EDWARD
05/04/90

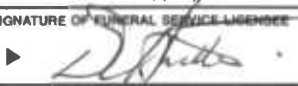


90-13257

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EDWARD K. MILLER | | | | 2. DATE OF DEATH MONTH 05 DAY 11 YEAR 90 | | 3. TIME OF DEATH 0450 M | |
| 4. SOCIAL SECURITY NUMBER 214 03 8882 | | 5. SEX MALE <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 95 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10/25/94 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH Baltimore City | | | | 10a. STATE Maryland | | 10b. COUNTY Washington | |
| 10c. CITY, TOWN OR LOCATION Boonsboro | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER U 1 Blue Ridge Drive | |
| 10f. ZIP CODE 21713 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cabinet Maker | | | | 16b. KIND OF BUSINESS/INDUSTRY Furniture | | | |
| 17. FATHER'S NAME (First, Middle, Last) Urias Miller | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Keeny | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Rachel A. Miller | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) U1 Blue Ridge Drive Boonsboro, Maryland 21713 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Meadow Branch Cemetery | | | |
| 20c. LOCATION — City or Town, State Westminster, Maryland | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lynn Burge Henss | | | |
| 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road, Baltimore, Md 21211 | | | | 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DIFFUSE CARCINOMATOSIS OF UNKNOWN PRIMARY b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| 24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NONE | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) N/A | | | | 28b. TIME OF INJURY M | | | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED N/A | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Shatnagar MD | | | |
| 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year) May 11, 1990 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MOHIT SHATNAGAR JOHN HOPKINS HOSPITAL | | | | | | | |
| 31. FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE Gula Davidson-Randall | | | |

90 13258

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CATHERINE ESTELLE NEAL | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 13 1990 | | 3. TIME OF DEATH 2:00 A.M. | |
| 4. SOCIAL SECURITY NUMBER 216-10-9444 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 90 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 19 1899 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH Baltimore City | | | | 10a. STATE Maryland | | | |
| 10b. COUNTY Baltimore | | | | 10c. CITY, TOWN OR LOCATION Catonsville | | | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 333 Harlem Lane | | | |
| 10f. ZIP CODE 21228 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) None | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self Employed | | 16b. KIND OF BUSINESS/INDUSTRY House Keeping | | | |
| 17. FATHER'S NAME (First, Middle, Last) Henry Simms | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Jenkins | | | |
| 19a. INFORMANT'S NAME (Type/Print) Stephen F. Neal | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 Georgia Ave., Linthicum, Maryland 21090 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Ignatius Church Cemetery | | 20c. LOCATION — City or Town, State Chapel Point, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD. 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → sepsis DUE TO (OR AS A CONSEQUENCE OF): b. UTI - Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Dementia DUE TO (OR AS A CONSEQUENCE OF): d. ASCD Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D 26256 | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1940 W. BALTIMORE ST, BALTO MD 21225 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

000001 00

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ANNE M. NAGLE | | | | 2. DATE OF DEATH MONTH 5 DAY 10 YEAR 90 | | 3. TIME OF DEATH 11:10 P M | |
| 4. SOCIAL SECURITY NUMBER 218-03-5154 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) OCT. 4, 1918 | |
| 9a. FACILITY NAME (If not institution, give street and number) Mercy Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH - - - | |
| 10a. STATE MD | | 10b. COUNTY - - - | | 10c. CITY, TOWN OR LOCATION Baltimore City | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 117 N. Kenwood Ave. | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NA College (1-4 or 5+) NA | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) PAUL MEDINGER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EMMA M. DRUERY | | | |
| 19a. INFORMANT'S NAME (Type/Print) GEORGE L. NAGLE (HUSBAND) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 N. KENWOOD AVE., BALTO., MD. 21224 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY REDEEMER | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Eugene J. Lestner</i> | | | | 22. NAME AND ADDRESS OF FACILITY SCHIMUNEK FUNERAL HOMES, INC. 3331 BREHMS LANE, BALTO., MD. 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Malignancy of the Common Bile Duct DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death 6 mos. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pleural effusion | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John M. Williams MD</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5460 Hound Hill Ct. Columbia, MD 21045 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13529

90 13260

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Price, Simmie Lee</i> | | | | 2. DATE OF DEATH MONTH <i>5</i> DAY <i>12</i> YEAR <i>90</i> | | 3. TIME OF DEATH <i>745 P M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>284-18-4759</i> | | 5. SEX <i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>71</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>1-8-19</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>Liberty Medical Hospital</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE <i>MD</i> | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>1908 N. Monroe St</i> | |
| 10f. ZIP CODE <i>21217</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WW II</i> | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. <i>Black</i> | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Mechanic</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Betty Epps</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1821 W. North Ave Balt. Md. 21217</i> | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Garrison Forest V.A. Cemetery</i> | | | |
| 20c. LOCATION — City or Town, State <i>Owings Mills, Md.</i> | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Melvin L. Evans</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY <i>Evans Funeral Home Pky</i> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Right Brain Cerebellar Infarction</i> Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Hypertension</i> <i>Cardiomegaly</i> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | | |
| 28b. TIME OF INJURY <i>M</i> | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>B. Kutsche M.D.</i> | | | | 29c. LICENSE NUMBER <i>D-35788</i> | | | |
| 29d. DATE SIGNED (Month, Day, Year) <i>5/12/90</i> | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>B Kutsche MD LIBERTY MED CENTER 2400 LIBERTY HEIGHTS Balt. MD. 21215</i> | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 15 1990</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EVA MARIA PESZEWSKA | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 12 1990 | | 3. TIME OF DEATH 8:25 p.m. | |
| 4. SOCIAL SECURITY NUMBER 142-34-3484 | | 8. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JUNE 20, 1933 | |
| 9a. FACILITY NAME (If not institution, give street and number) 6465 TROTTER ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH CLARKSVILLE | | | | 9c. COUNTY OF DEATH HOWARD | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY HOWARD | | 10c. CITY, TOWN OR LOCATION CLARKSVILLE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6465 TROTTER ROAD | | 10f. ZIP CODE 21029 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ENGINEER | | 16b. KIND OF BUSINESS/INDUSTRY LAND SURVEYOR | | | |
| 17. FATHER'S NAME (First, Middle, Last) PAUL T. MIX | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LUCIA FRANKUS | | | |
| 19a. INFORMANT'S NAME (Type/Print) KATHLEEN KRALOWEC | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6465 TROTTER ROAD CLARKSVILLE MARYLAND 21029 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ST. LOUIS CEMETERY | | 20c. LOCATION — City or Town, State CLARKSVILLE MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Russell Witzke</i> | | | | 22. NAME AND ADDRESS OF FACILITY LEROY & RUSSELL WITZKE FUNERAL HOME OF COLUMBIA 5555 TWIN KNOLLS RD COLUMBIA MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC BREAST CANCER Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 3478. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. G. Nelson MD PhD</i> | | 29c. LICENSE NUMBER D39683 | | 29d. DATE SIGNED (Month, Day, Year) MAY 14, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM G. NELSON MD PhD 600 N. WOLFE ST, BALTIMORE, MD, 21205 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CLAUDE J. ROBINSON | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 14, 1990 | | 3. TIME OF DEATH 10:30 A.M. | |
| 4. SOCIAL SECURITY NUMBER 217-03-3912 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4/3/1910 | |
| 8. BIRTHPLACE (State or Foreign Country) SOUTH CAROLINA | | | | 9a. FACILITY NAME (If not institution, give street and number) 2003 HARLEM AVENUE | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MARYLAND | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2003 HARLEM AVENUE | |
| 10f. ZIP CODE 21217 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WELDER | | | | 16b. KIND OF BUSINESS/INDUSTRY BETH. STEEL CORP. | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN DAC ROBINSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) CHARMANE VIRGINIA HAROLD & ROBINSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2003 HARLEM AVENUE, BALTIMORE, MD. 21217 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MORELAND MEMORIAL PARK CEMETERY | | | |
| 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harold E. Nutter</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY NUTTER FUNERAL HOMES, INC. 21216 2501 GWYNNS FALLS PKWY., BALTIMORE, MD. | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Carcinoma of Prostate</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | |
| 29c. LICENSE NUMBER D00359 | | | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A.C. ALEUZATOS, M.D. 301 ST. PAUL PLACE BALTO. MD 21202 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CYNTHIA R. ROWE | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 10, 1990 | | | | 3. TIME OF DEATH 7:10a.m. M | | | |
| 4. SOCIAL SECURITY NUMBER 216 36 0386 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 49 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-23-40 | | 8. BIRTHPLACE (State or Foreign Country) Md | | | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH BALTIMORE CITY | | | |
| 10a. STATE Md | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 1503 N. LAKEWOOD AVE | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) Secondary | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor Holiday INN | | 16. KIND OF BUSINESS/INDUSTRY HOTEL | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Wilmore Jones | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Geneva Royden | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Geneva Parker | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1503 N. Lakewood Ave BALTO, Md, 21213 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt CALVARY Cem. | | 20c. LOCATION — City or Town, State A.A. County, Md | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Timothy Reader | | | | 22. NAME AND ADDRESS OF FACILITY Locha Funeral Home 1304 N Central Ave | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardogenic shock / Ischemic Cardiomyopathy 1d/3 yrs DUE TO (OR AS A CONSEQUENCE OF): b. Cardiac arrhythmias 30 mins DUE TO (OR AS A CONSEQUENCE OF): c. (CHF) Congestive heart Failure years DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER David W. Allen MD | | 29c. LICENSE NUMBER E9814 | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID W. Allen, MD Johns Hopkins Hospital Baltimore, MD | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE John A. Decker | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00:00:00

90 13264

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LILLIAN E SHIPLEY | | | | 2. DATE OF DEATH MONTH 05 DAY 14 YEAR 90 | | 3. TIME OF DEATH 9:25 a.m. | |
| 4. SOCIAL SECURITY NUMBER 214-20-9432 A | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/26/05 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE | |
| 9c. COUNTY OF DEATH ANNE ARUNDEL | | | | 10a. STATE MARYLAND | | 10b. COUNTY -- | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3939 ROLAND AVENUE | |
| 10f. ZIP CODE 21211 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY HOME | |
| 17. FATHER'S NAME (First, Middle, Last) FRANK H. SHIELDS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ELLA E. SEIPP | | | |
| 19a. INFORMANT'S NAME (Type/Print) S. THOMAS SHIPLEY JR. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 ROANOKE DRIVE, CATONSVILLE, MD. 21228 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) NEW CATHEDRAL CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Linda M. Witzke</i> | | | | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | | | |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest & Shock Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Heart block c. ASCVD CHF d. Diabetes Mellitus | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mustafa C. Oz, M.D.</i> | | | | 29c. LICENSE NUMBER D 22206 | | 29d. DATE SIGNED (Month, Day, Year) 5 18 90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MUSTAFA C OZ, M.D. 273B PENINSULA FARM ROAD ARNOLD, MARYLAND 21012 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Pond</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LEROY SINGLETARY | | | | 2. DATE OF DEATH MONTH 05 DAY 12 YEAR 90 | | 3. TIME OF DEATH 8:30 A M | |
| 4. SOCIAL SECURITY NUMBER 213-01-5913 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 85 YRS. | IF UNDER 1 YEAR MONTHS 05 DAYS 05 | IF UNDER 24 HRS. HOURS 05 MIN. | 7. DATE OF BIRTH (Month, Day, Year) 2 6 05 | |
| 9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| 10a. STATE Md. | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Balto. | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 33 Hill Rd. | | 10f. ZIP CODE 21146 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY H. Claff & Co. | | 17. FATHER'S NAME (First, Middle, Last) William Singletary | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Gasque | | | | 19a. INFORMANT'S NAME (Type/Print) Melvin Singletary | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 812 McCabe Ave., Balto., Md. 21212 | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cem. | | 20c. LOCATION — City or Town, State Catonsville, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE John March | | | | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Ave. | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Electromechanical dissociation Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Asystole Seizure PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recent Right Basal Ganglia CVA | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Janice Harms MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5-12-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JANICE HARMS MD UNION MEMORIAL HOSPITAL BALTIMORE MD | | | | 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.


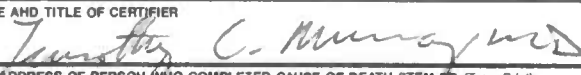

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1 MAY 1972
10/20/71

90 13266

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Roberta J SEWARD | | | | 2. DATE OF DEATH MONTH DAY YEAR May 12, 1990 | | 3. TIME OF DEATH 12:30 A M | |
| 4. SOCIAL SECURITY NUMBER 215-14-5294 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) AUG. 5 1912 | |
| 8. BIRTHPLACE (State or Foreign Country) MD. | | | | 9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE MD. | | 10b. COUNTY --- | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 7768 GOUGH ST. | |
| 10f. ZIP CODE 21224 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last) GEORGE H. OHLE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH McNULTY | | | |
| 19a. INFORMANT'S NAME (Type/Print) JOHN W. SEWARD, SR. (HUSBAND) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7768 GOUGH ST., BALTIMORE, MD. 21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) OAK LAWN CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Balto, Md. 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Diabetic Ketoacidosis with pressured Septic Shock DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { Severe Acidosis causing Electrical Vascular Instability DUE TO (OR AS A CONSEQUENCE OF): Anemia with upper Gastrointestinal Bleed DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypothyroidism Hypertension | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  Timothy C. Murray MD | | | | 29c. LICENSE NUMBER N/A | | 29d. DATE SIGNED (Month, Day, Year) 5-12-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Timothy Murray MD 9000 Franklin Square Drive 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13267

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Margaret C. Slocum | | | | 2. DATE OF DEATH MONTH 5 / DAY 12 / YEAR 90 | | 3. TIME OF DEATH 8:30 AM | |
| 4. SOCIAL SECURITY NUMBER 218-46-0323 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) DEC. 19, 1898 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | 9a. FACILITY NAME (If not institution, give street and number) DULANEY TOWSON NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY -- -- -- | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3407 KENTUCKY AVE. | | 10f. ZIP CODE 21213 | |
| 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NA College (1-4 or 5+) NA | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last) FREDERICK SCHMITT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CATHERINE SCHMIDT | | | |
| 19a. INFORMANT'S NAME (Type/Print) (DAUGHTER) MRS. CATHERINE CUNNINGHAM | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3407 KENTUCKY AVE., BALTIMORE, MD. 21213 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY SCHIMUNEK FUNERAL HOMES, INC. 3331 BREHMS LANE, BALTO., MD. 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Stroke</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely lie conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <u>1 week</u> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>osteoporosis</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER P20673 | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GEORGE LOWE M. D., 3703 BELAIR ROAD, BALTIMORE, MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES ELMER STILL | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 03 90 | | 3. TIME OF DEATH 2:30 A^M | |
| 4. SOCIAL SECURITY NUMBER 317-12-3049 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11/03/1902 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE MD | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Parkton | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 20328 YORK ROAD | |
| 10f. ZIP CODE 21120 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dairy Farmer | | | | 16b. KIND OF BUSINESS/INDUSTRY Operated a Dairy Farm | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles Still | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura (Unknown) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Helen M. Still | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20328 York Rd., Parkton, MD 21120 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Stabler's Cemetery | | 20c. LOCATION — City or Town, State Parkton, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J. J. Hartenstein</i> | | | | 22. NAME AND ADDRESS OF FACILITY J. J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PULMONARY EMBOLISM DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST HIP FRACTURE DUE TO (OR AS A CONSEQUENCE OF): Pneumonia | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Elisabeth K. Wees, MD</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/3/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR LUCAS 6701 N CHARLES STREET TOWSON MD 21204 GBMC | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEASED'S NAME (First, Middle, Last) LEO A. SMITH | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 2:05 P M | |
| 4. SOCIAL SECURITY NUMBER 217-07-9859 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 08 25 14 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) 3838 Roland Avenue, Apt. 605 | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH | | | | | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 3838 ROLAND AVENUE APT. 605 | | | | 10f. ZIP CODE 21211 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RETIRED | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) LEO A. SMITH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) THERESA V. TARR | | | |
| 19a. INFORMANT'S NAME (Type/Print) RITA KETCHUM | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 DANZA ROAD, SEVERN, MD. 21144 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY A. ALAN SEITZ, JR. FUNERAL HOME 3818 ROLAND AVENUE, BALTIMORE, MD. 21211 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate Carcinoma | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Inspection |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH XXX Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-12-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann M. Dixon, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 v1 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

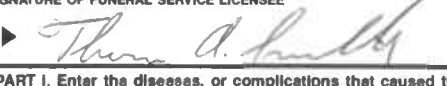
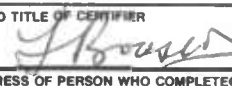
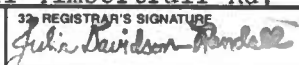
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOAN R. STRUTT | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 11 90 | | 3. TIME OF DEATH M M | |
| 4. SOCIAL SECURITY NUMBER 212-03-7290-A | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2-27-16 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) 9 Nantucket Garth | | 9b. CITY, TOWN OR LOCATION OF DEATH Phoenix | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Phoenix | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 9 Nantucket Garth | |
| 10f. ZIP CODE 21131 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 yrs College (1-4 or 5+) 2 yrs | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Comptroller | | | | 16b. KIND OF BUSINESS/INDUSTRY Strutt Group Inc. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Ernest Bartholomew | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie Matilda Dillon | | | |
| 19a. INFORMANT'S NAME (Type/Print) George F. Strutt | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Nantucket Garth Phoenix, Md. 21131 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley 5-15-90 | | | |
| 20c. LOCATION — City or Town, State Timonium, Md. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | |
| 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) M 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER  Larry Boas M.D. | | | |
| 29c. LICENSE NUMBER D15871 | | | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Larry Boas M.D. 1111 Timbertrail Rd. LAWRENCE BOAS MD Towson Md 21204 | | | | 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | |
| 32. REGISTRAR'S SIGNATURE  | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CARLA TILLMAN | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 10:30 A M | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) YRS. 4 | | 7. DATE OF BIRTH (Month, Day, Year) 1-17-90 | | 8. BIRTHPLACE (State or Foreign Country) MD. |
| 9a. FACILITY NAME (If not institution, give street and number) 978 N. Franklinton Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| 10a. STATE MD | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 978 N. FRANKLINTOWN Rd | | 10f. ZIP CODE 21216 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: B | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) INFANT | | | | 16b. KIND OF BUSINESS/INDUSTRY | | 17. FATHER'S NAME (First, Middle, Last) JOHNNIE L. BROWN | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) TASLA TILLMAN | | | | 19a. INFORMANT'S NAME (Type/Print) TASLA TILLMAN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 978 N. FRANKLINTOWN Rd - Baltimore MD 21216 | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. LOCATION — City or Town, State Anne Arundel Co. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wm C. Brown | | | | 22. NAME AND ADDRESS OF FACILITY 1206 W. North Ave William C. Brown Community F.H. | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sudden Infant Death Syndrome DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH XXX Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Wm C. Brown | | 29c. LICENSE NUMBER OCME | |
| 29d. DATE SIGNED (Month, Day, Year) 5-12-90 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita A. Korell, M.D., Assistant 111 Penn Street, Baltimore, MD 21201 vl | | 31. DATE FILED (Month, Day, Year) MAY 15 1990 | |
| 32. REGISTRAR'S SIGNATURE John Davidson-Hendall | | | | 33. DATE OF DEATH (Month, Day, Year) 5-11-90 | | 34. TIME OF DEATH 10:30 A M | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Turner, Vernon | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 12 90 | | 3. TIME OF DEATH 7:10 M | |
| 4. SOCIAL SECURITY NUMBER 225-42-6347 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 51 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-22-38 | |
| 8. FACILITY NAME (If not institution, give street and number) UMH | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Balt MD 21201 | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10a. STATE MD | | 10b. COUNTY | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 10e. STREET AND NUMBER 1556 N. WOODYEAR ST. | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th GRADE College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION WORKER | |
| 17. FATHER'S NAME (First, Middle, Last) VERNON TURNER SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EVALENA BAILEY | | | |
| 19a. INFORMANT'S NAME (Type/Print) ANNA L. TURNER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1556 N. WOODYEAR ST. BALTO, MD. 21217 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) PINE LEVEL BAPTIST CHURCH | | 20c. LOCATION — City or Town, State CAPRON VA. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gladys Wane | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → metastatic Head & Neck Cancer DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypercalcemia | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER MD | | | | 29c. LICENSE NUMBER 037517 | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David C. Rubin 22 S. Greene St Balt MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE Johanna Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) SAMUEL TITUS WHITE | | | | 2. DATE OF DEATH MONTH 05 - DAY 11 - YEAR 1990 | | 3. TIME OF DEATH 5:45 P M | |
| 4. SOCIAL SECURITY NUMBER 219-07-7169 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) NOV 8, 1913 Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore MD | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore City | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2920 CHERRYLAND ROAD | | | |
| 10f. ZIP CODE 21225 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MAINTENANCE | | 16b. KIND OF BUSINESS/INDUSTRY CITY OF BALTIMORE HOUSING AUTHORITY | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM WHITE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ADDIE MELBOURNE | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. AGNES R. MONROE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 916 LYNDBURST STREET, BALTIMORE, MD. 21229 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK | | 20c. LOCATION — City or Town, State BALTO COUNTY, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ernest R. Fennell</i> | | | | 22. NAME AND ADDRESS OF FACILITY NUTTER FUNERAL HOMES, INC. 21216 2501 GWYNNS FALLS PKWY. BALTO, MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Renal Failure DUE TO (OR AS A CONSEQUENCE OF): b. Tumor Right Lung DUE TO (OR AS A CONSEQUENCE OF): c. metastases to liver DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1 wk. 2 months 1 month | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO <i>Partial exam.</i> | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert C. Dent Jr.</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Dent, Jr. 3001 S. Hemmick St. Baltimore MD 21230 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-1-60

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT LEE. WASHINGTON | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 12:20 P M | |
| 4. SOCIAL SECURITY NUMBER 218-44-3568 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 43 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-02-46 | |
| 8. BIRTHPLACE (State or Foreign Country) S.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MD | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 1728 N. BROADWAY | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th GRADE | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) NATHANIEL WASHINGTON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) JUANITA ANDREWS | | | |
| 19a. INFORMANT'S NAME (Type/Print) ISABELLA WASHINGTON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 ENCHANTED RD. OWINGS MILLS, MD. 21117 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | 20c. LOCATION — City or Town, State LANDSDOWNE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gladys Ware | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Head & Abdominal Injuries DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Portal Cirrhoses | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation XXXX Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 5-8-90 | | 28b. TIME OF INJURY Unk. M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED Subject fell down stairs | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) home | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1728 N. Broadway, Baltimore City, Maryland | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Wynne Melhale | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-12-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita A. Korell, M.D., Assistant 111 Penn Street, Baltimore, MD 21201 vl | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE John Swickard-Robert | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) TIMOTHY HOWARD WATTS | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 12 1990 | | 3. TIME OF DEATH 12:37A M | |
| 4. SOCIAL SECURITY NUMBER 214-08-0706 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 42 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) OCT. 23, 1947 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) PENINSULA GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY | |
| 9c. COUNTY OF DEATH WICOMICO | | | | 10a. STATE MARYLAND | | 10b. COUNTY HOWARD | |
| 10c. CITY, TOWN OR LOCATION COLUMBIA | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 9713 CLOCKTOWER LANE | |
| 10f. ZIP CODE 21046 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1965-1967 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SYSTEMS ANALYST | | | | 16b. KIND OF BUSINESS/INDUSTRY COMPUTER SCIENCE | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN H. WATTS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SALOME | | | |
| 19a. INFORMANT'S NAME (Type/Print) SARA E. MILLER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9713 CLOCKTOWER LANE APT. 104 COLUMBIA, MD. 21046 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERANS CEMETERY | | | |
| 20c. LOCATION — City or Town, State OWINGS MILLS, MARYLAND | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sandra K. Witzke</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PULMONARY EMBOLI DUE TO (OR AS A CONSEQUENCE OF): b. CARDIOMEGALY WITH CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. SYSTEMIC LUPUS ERYTHEMATOSUS DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ronald S. Pototsky</i> | | | |
| 29c. LICENSE NUMBER D13004 | | | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ronald S. Pototsky, M.D. 821 Eutaw Street Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Center Walters | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-9-90 | | 3. TIME OF DEATH 7:37PM M | |
| 4. SOCIAL SECURITY NUMBER 249-02-8991 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4 5 33 | |
| 8. BIRTHPLACE (State or Foreign Country) South Carolina | | | | 9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE Maryland | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2626 Loyola Southway | |
| 10f. ZIP CODE 21215 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Mooch Walters | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Alice Walters | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2626 Loyola Southway Baltimore, Md 21215 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland National Mem. Ph | | 20c. LOCATION — City or Town, State Laurel Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Harvey Harris | | | | 22. NAME AND ADDRESS OF FACILITY Chatman-Harris F/H 1701 McCulloh St. Balto; Md 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease and chronic alcoholism DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? XXX YES 2 <input type="checkbox"/> NO HEAD ONLY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH XXX Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Julia C. Goodin, MD | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-10-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julia C. Goodin, MD 111 Penn Street, Baltimore, MD 21201 VC | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DOUGLAS MARK WEIDMAN | | | | | | 2. DATE OF DEATH MONTH DAY YEAR May 29, 1990 | | 3. TIME OF DEATH 5:20 P.M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 048-46-3060 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 26 YRS. | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) May 29, 1963 | | 8. BIRTHPLACE (State or Foreign Country) New York | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 6920 Donachie Road | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | | 9c. COUNTY OF DEATH Baltimore | | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Towson | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 6920 Donachie Road | | | | | | 10f. ZIP CODE 21239 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) 4 yrs. | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Claims Representative | | | | 16b. KIND OF BUSINESS/INDUSTRY Insurance Company | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Robert F. Weidman | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Barbara A. Wassmer | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Robert F. Weidman | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Buckley Court Towson, Maryland 21204 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crem. 5/14/90 | | | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald C. [Signature]</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY 1050 York Rd. 21204 Ruck Towson Funeral Home, Inc. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Asphyxia from Hanging DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | Approximate Interval Between Onset and Death Sudden | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) 5-9-90 | | 28b. TIME OF INJURY P.M. | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED Hanging | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Boxroom. | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6920 Donachie Drive - Apt 148 Towson Md 21239 | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles F. O'Donnell</i> | | | | | | 29c. LICENSE NUMBER D-09383 | | 29d. DATE SIGNED (Month, Day, Year) May 10, 1990 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles F. O'Donnell MD 7501 York Rd Towson Md 21204 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20 1951

90 13278

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Bertha L. Warren | | | | 2. DATE OF DEATH MONTH DAY YEAR May 14, 1990 | | 3. TIME OF DEATH 3 33 A.M. | |
| 4. SOCIAL SECURITY NUMBER 408-38-0983A | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-10-1927 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Medical Cen. | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH ----- | | | | 10a. STATE Md. | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 7838 St. Fabian Lane | |
| 10f. ZIP CODE 2122 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nursing Assistant | | | | 16b. KIND OF BUSINESS/INDUSTRY Hospital | | | |
| 17. FATHER'S NAME (First, Middle, Last) Arthur Widener | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Isabelle Andrews | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Wilmer C. Warren, Sr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7838 St. Fabian Lane Balto., Md. 21222 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery | | | |
| 20c. LOCATION — City or Town, State Balto., Md. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY Hartley Miller Funeral Home 7527 Harford Rd. Balto., Md. 21234 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. COPD exacerbation DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Smoking Tobacco DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD BILATERAL PLEURAL EFFUSIONS HISTORY OF RECENT SUBARACHNOID BLEED X2 | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) May 14, 1990 | | | |
| 28b. TIME OF INJURY M | | | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER 137093 | | | |
| 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. CLOVEREN FRANCIS SCOTT KEY HOSPITAL | | | |
| 31. DATE OF DEATH (Month, Day, Year) MAY 14 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13272

2019-07-10 10:00

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13279

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Emily B. Young | | | | 2. DATE OF DEATH MONTH DAY YEAR May 10, 1990 | | 3. TIME OF DEATH 9: A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 216-20-9462 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-21-05 | | 8. BIRTHPLACE (State or Foreign Country) Md. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | | 9c. COUNTY OF DEATH | | | | |
| 10a. STATE Md. | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Balto. | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 727 Druid Park Lake Dr. | | | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Thomas | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Josephine Thomas | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Allen | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 625 Hillview Rd., Balto., Md. 21225 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) King Mem. Pk. | | | 20c. LOCATION — City or Town, State Randallstown, Md. | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Portia Elvira | | | | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Ave. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aortic Dissection DUE TO (OR AS A CONSEQUENCE OF): b. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 9 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 10 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Harry M. Harris, M.D. | | | | 29c. LICENSE NUMBER N/A | | 29d. DATE SIGNED (Month, Day, Year) 5-10-90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Harry M. Harris, M.D. c/o Maryland General Hospital | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE Johanna Davidson-Randall | | | | | | | |

FORM 02

APR 1964

90 13280

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) James L. Yirka | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 10 1990 | | 3. TIME OF DEATH 7:00 A.M. | |
| 4. SOCIAL SECURITY NUMBER 214 03 6890 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7-17-1910 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 3815 - 8th Street | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH ===== | | | | | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY ===== | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 3815 - 8th Street | | | | 10f. ZIP CODE 21225 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Batch Mixer | | 16b. KIND OF BUSINESS/INDUSTRY Dupont Paints | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Margaret Deavers | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7508 Pillsbury Place Glen Burnie, Maryland 21061 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donna M. Zimurski</i> | | | | 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Artery Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> a. DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerosis b. DUE TO (OR AS A CONSEQUENCE OF): Cardiovascular Disease c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): </div> <div style="width: 35%; text-align: center;"> Approximate Interval Between Onset and Death </div> </div> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral infarction | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jose Presbitero MD</i> | | | | 29c. LICENSE NUMBER D16208 | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jose Presbitero 7845 Oakwood Rd. Suite 107 Glen Burnie, MD. 21061 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | 32. REGISTRAR'S SIGNATURE <i>John S. ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

90 13281

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WALTER S. ADAMARCZYK | | | | 2. DATE OF DEATH MONTH DAY YEAR 05- 10- 90 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 184-28-8281 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-11-27 | |
| 8. BIRTHPLACE (State or Foreign Country) POLAND | | 9a. FACILITY NAME (If not institution, give street and number) FRANCIS SCOTT KEY MED. CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 527 S. LUZERNE AVENUE | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MACHINE OPERATOR | | 16b. KIND OF BUSINESS/INDUSTRY AMERICAN CAN | | | |
| 17. FATHER'S NAME (First, Middle, Last) PETE ADAMARCZYK | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) VERONICA | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. JANINA ADAMARCZYK | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 527 S. LUZERNE AVENUE BALTO. MD. 21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ST. STANISLAUS CEMETERY | | 20c. LOCATION — City or Town, State BALTO. MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raymond L. Kaczorowski</i> | | | | 22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224 | | | |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Arteriosclerotic Heart Disease</i> | | | | | |
| | | b. <i>Arteriosclerosis</i> | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Melito M. Torres, M.D.</i> | | | | 29c. LICENSE NUMBER 211150 | | 29d. DATE SIGNED (Month, Day, Year) May 11, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MELITO M. TORRES, M.D. 441 S. ELLWOOD AVENUE BALTIMORE, MD. 21224 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

27. 21 00

Handwritten signature or text, possibly "James H. Brown"

90 13282

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Tempy Byrd</i> | | | | 2. DATE OF DEATH MONTH <i>5</i> DAY <i>14</i> YEAR <i>90</i> | | 3. TIME OF DEATH <i>10:30 AM</i> | |
| 4. SOCIAL SECURITY NUMBER <i>217-24-4290</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>59</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>12-13-30</i> | |
| 8. BIRTHPLACE (State or Foreign County) <i>Maryland</i> | | | | 9. FACILITY NAME (If not institution, give street and number) <i>Deaton Hospital & Medical Center</i> | | 10. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | |
| 11. RESIDENCE OF DECEDENT | | | | 12. COUNTY OF DEATH <i>City</i> | | 13. COUNTY OF DEATH | |
| 10a. STATE <i>MARYLAND</i> | | 10b. COUNTY <i>N/A</i> | | 10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i> | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>1204 WEST FAYETTE STREET</i> | | | | 10f. ZIP CODE <i>21223</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>UNEMPLOYED</i> | | 17. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>JOSEPH D. LOGAN</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>MAMIE BROWN</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>PATRICIA ANN JOHNSON</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>809 A DARTMOUTH ROAD</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>MOUNT ZION CEMETERY</i> | | 20c. LOCATION — City or Town, State <i>BALTIMORE, MARYLAND</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Almitte K. Jones</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>BROWN/THOMPSON F.H. P.O. BOX 4433 (21223)</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>LARYNGEAL CANCER</i> Due to (or as a consequence of): a. <i>TOBACCO ABUSE</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate interval between Onset and Death <i>2 YEARS</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>James P. Richardson MD</i> | | | | 29c. LICENSE NUMBER <i>027394</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>5/16/90</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>JAMES P. RICHARDSON MD 601 S. CHARLES ST. BALTO. MD 21230</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 16 1990</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Windell Bowser | | | | 2. DATE OF DEATH MONTH 05 DAY 12 YEAR 90 | | 3. TIME OF DEATH 08:44 P M | |
| 4. SOCIAL SECURITY NUMBER 213-24-0596 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 60 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 07-11-29 | 8. BIRTHPLACE (State or Foreign Country) BALTO., MD. | | |
| 9a. FACILITY NAME (If not institution, give street and number) BON SECOURS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2344 LAURETTA AVENUE | | | | 10f. ZIP CODE 21223 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) SAMUEL BOWSER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) VIOLA WARD | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARY F. BOWSER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2344 LAURETTA AVENUE (21223) | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dynette K. Jones | | | | 22. NAME AND ADDRESS OF FACILITY BROWN/THOMPSON F.H. P.O. BOX 4433 (21223) | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Upper Gastrointestinal Bleeding DUE TO (OR AS A CONSEQUENCE OF): Liver Failure DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST HIV Disease DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HIV Disease | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Sabah Al-Attar, MD | | | | 29c. LICENSE NUMBER D37725 | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sabah A. Al-Attar, Bon Secour Hospital, Baltimore, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE Juli Davidson-Rodella | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

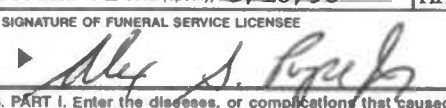

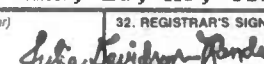
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) FLORENCE HORTENSE BRYAN | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 14 1990 | | 3. TIME OF DEATH A M 12:15 A | |
| 4. SOCIAL SECURITY NUMBER 577-50-8073 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 54 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) NOV 22 1935 | |
| 9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA | | 9c. COUNTY OF DEATH MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE DISTRICT OF COLUMBIA | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Washington, D.C. | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3916 SOUTHERN AVENUE | | | | 10f. ZIP CODE 20020 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (14 or 6+) SCHOOL TEACHER | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) EDUCATION | | 17. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN ABEL BRYAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) RUTH ELVA LLOYD | | | |
| 19a. INFORMANT'S NAME (Type/Print) ELVA B. NELSON (Sister) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3533 EDWARD STREET, LANDOVER, MD 20086 20785 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 5/18/90 | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND NATIONAL CEMETERY | | 20c. LOCATION — City or Town, State LAUREL, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M859 | | | | 22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOME 2617 Pennsylvania Avenue, SE DC 20020 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYCOSIS FUNGOIDES DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  MD | | | | 29c. LICENSE NUMBER D 35835 | | 29d. DATE SIGNED (Month, Day, Year) 15 May 90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRIAN P. MONAHAN, LT, MC, USNR | | | | 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | |
| | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Nathan Bloom</i> NATHAN BLOOM | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 11 80 | | 3. TIME OF DEATH 9:45 P.M. | |
| 4. SOCIAL SECURITY NUMBER 213-01-1916 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2/18/89 | |
| 8. BIRTHPLACE (State or Foreign) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>Lovindale</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | |
| 9c. COUNTY OF DEATH | | | | RESIDENCE OF DECEDENT | | | |
| 10a. STATE <i>Md.</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>6317 Park Heights Ave. Apt. 619</i> | | | | 10f. ZIP CODE <i>21215</i> | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <i>12</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER | | 16b. KIND OF BUSINESS/INDUSTRY CLOTHING STORE | |
| 17. FATHER'S NAME (First, Middle, Last) MAURICE BLOOM | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LENA UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. ANNETTE BLOOM | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6317 PARK HTS. AVE., APT. 619 BALTO., MD 21215 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BETH EL MEMORIAL PARK | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jack H. Horner</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>RENAL CELL CARCINOMA</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death <i>5 years</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. J. Lucca</i> A J Lucca MD | | | | 29c. LICENSE NUMBER D30951 | | 29d. DATE SIGNED (Month, Day, Year) 5-12-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A J Lucca 2434 W BELMONT AVE. BALTO 21215-5299 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John L. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REG. NO.

OHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) SELMA BARUCHA BAUM | | | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 8, 1990 | | 3. TIME OF DEATH 3:45 P. M | |
| 4. SOCIAL SECURITY NUMBER 073-26-2145 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) APR. 10, 1918 | | 8. BIRTHPLACE (State or Foreign Country) POLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) 12138 HENESON GARTH | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH OWINGS MILLS | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE NEW JERSEY | | 10b. COUNTY CHERRY HILL | | 10c. CITY, TOWN OR LOCATION CHERRY HILL | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 301 VALLEY RUN DRIVE | | | | 10f. ZIP CODE 08002 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY AT HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH JAKOBOWITZ | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) REBECCA BLUM | | | |
| 19a. INFORMANT'S NAME (Type/Print) JACK BAUM | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 VALLEY RUN DR. CHERRY HILL, NJ 08002 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BETH EL MEMORIAL PARK | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sydney L. Stellan</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of stomach DUE TO (OR AS A CONSEQUENCE OF): Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death 6 mo. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Henry A. Pitt M.D.</i> | | | | | | 29c. LICENSE NUMBER D21906 | | 29d. DATE SIGNED (Month, Day, Year) 5/9/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Henry A. Pitt, M.D., Johns Hopkins Hospital, 600 N. Wolfe Street, Baltimore 21205 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Agnes Barefoot | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 10:35 M | |
| 4. SOCIAL SECURITY NUMBER 240-32-1302 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-16-23 | |
| 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Hosp - Lord Bldg. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Balto, Md. | | 9c. COUNTY OF DEATH | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Essex | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5 Brett Court | | | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 8+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Lester Taylor | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ada Bullock | | | |
| 19a. INFORMANT'S NAME (Type/Print) Carolyn Wirth | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Brett Court Balto. Md. 21221 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Old Bluff Pers. Cemetery | | 20c. LOCATION — City or Town, State North Carolina | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Connelly Funeral Home | | | | 22. NAME AND ADDRESS OF FACILITY 21221 ConnellyFuneralHome300MaceAve.Balto.Md. | | | |
| 23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → metastatic invasion of lung Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Goyto - mds | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) BERTHA BRZECZKO | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 1990 | | 3. TIME OF DEATH 12:42AM | |
| 4. SOCIAL SECURITY NUMBER 212-16-8577 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-16-1917 | |
| 8. BIRTHPLACE (State or Foreign Country) PA. | | | | 9a. FACILITY NAME (If not institution, give street and number) Church Hospital Corporation | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE Maryland | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION Baltimore, City | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 936 South East Ave. | |
| 10f. ZIP CODE 21224 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: W | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 7TH GR | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRESS OPERATOR | | 16b. KIND OF BUSINESS/INDUSTRY CANNING CO | |
| 17. FATHER'S NAME (First, Middle, Last) TERESA MAJEWSKI | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BERTHA OSTROWSKA | | | |
| 19a. INFORMANT'S NAME (Type/Print) EVELYN PICKER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1226 JUNE RD. 21227 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ST STANISLAUS | | 20c. LOCATION — City or Town, State BALTO | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edward J. Weber | | | | 22. NAME AND ADDRESS OF FACILITY EDWARD J WEBER 4015 CHESTER ST | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septic Shock Septic Shock a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Unknown Unknown c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death 12 hours |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Heart failure, Renal failure Heart Failure, Renal Failure | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John D. Hummel M.D. | | | | 29c. LICENSE NUMBER 1 M.D. | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John D. Hummel Church Home Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE Gula Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) GOLDIE BROWN | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 13 1990 | | 3. TIME OF DEATH 12 45 PM | |
| 4. SOCIAL SECURITY NUMBER 214-12-0482 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 04-09-20 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Bon Secours Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, Maryland | |
| 9c. COUNTY OF DEATH | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 911 Lyndhurst Street | | 10f. ZIP CODE 21229 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (14 or 16+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Luberta Pritchard | | | |
| 19a. INFORMANT'S NAME (Type/Print) Athena Houchins | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 N. Monroe St. Baltimore MD 21223 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cemetery Catonsville MD | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gloria Adams Jones | | 22. NAME AND ADDRESS OF FUNERAL HOME MARSHALL W. JONES, JR., F.H.A. 4101 Edmondson Ave. 21229 | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMA OF OVARIES DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. METASTATIC TUMOR TO LIVER - COLON - OMENTUM DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHOLELITHIASIS. DIABETES MELLITUS HYPERTENSION. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER M.D. | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) MAY 13 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH HUBAYKAH. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE Gloria Davidson-Rendall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Laura Mary BAILEY | | | | 2. DATE OF DEATH MONTH DAY YEAR May 15, 1990 | | 3. TIME OF DEATH 2:29 a.m. | |
| 4. SOCIAL SECURITY NUMBER 220-22-1318 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6-23-25 | |
| 9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH ROSSVILLE | | 9c. COUNTY OF DEATH Baltimore County | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1046 OLD NORTH POINT RD. | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH TRAVAGLINE, JR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY PATERRA | | | |
| 19a. INFORMANT'S NAME (Type/Print) GUY CANESTRARO | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1936 EWALD AVE., BALTO., MD. 21222 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY, INC. | | 20c. LOCATION — City or Town, State BALTO., MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Denise S. Leland | | | | 22. NAME AND ADDRESS OF FACILITY CIVILIAN/ROSEDALE F.N. 1211 CINEBARO AVE., BALTO., MD. 21237 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Obstructive Pulmonary Disease. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes. Hypertension. Congestive Heart Failure. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Jonathan Seidenberg, M.D. | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jonathan Seidenberg, M.D. 9000 Franklin Square Dr., Balto., 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ALMA BARNES | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 10 90 | | 3. TIME OF DEATH 6:20 A M | |
| 4. SOCIAL SECURITY NUMBER 212-20-7687 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 21 11 1920 | |
| 8. BIRTHPLACE (State or Foreign Country) N. Carolina | | | | 9a. FACILITY NAME (If not institution, give street and number) Homewood Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MD. | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1805 N. Fulton Avenue | |
| 10f. ZIP CODE 21217 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Robert Watkins | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Barnes | | | |
| 19a. INFORMANT'S NAME (Type/Print) Robert Pender | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 226 Channing St. N.E. Wash. D.C. 20002 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MD. National Mem. Park | | 20c. LOCATION — City or Town, State Laurel, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Doretha Hector #281 | | | | 22. NAME AND ADDRESS OF FACILITY E.L. Phillips F.H. 1721-27 N. Monroe St. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Possible sepsis DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. Diabetes Mellitus DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER C. S. WARRA, MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) MAY 16 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALMA BARNES, MD 2724 N. CHARLES ST. BALTIMORE, MD 21218 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE Gilia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT O. BELT | | | | 2. DATE OF DEATH MONTH 5 DAY 08 YEAR 90 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 214-12-0779 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4/18/19 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 107 CENTRAL AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH GLYNDON | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MD. | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION GLYNDON | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 107 CENTRAL AVENUE | | | | 10f. ZIP CODE 21071 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 8+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SELF EMPLOYED | | 16b. KIND OF BUSINESS/INDUSTRY PLUMBING | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas W. Wier 5-15-90</i> | | 22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BOARD, BALTO., MD. 21201 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Pleural effusion (malignant) DUE TO (OR AS A CONSEQUENCE OF): c. Adenocarcinoma of lung DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER PHILLIP N. PHILLIPS M.D. | | | | 29c. LICENSE NUMBER D36908 | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P. PHILLIPS, MD 500 MAIN ST., SUITE C, REISTERSTOWN, MD 21136 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



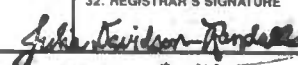
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 13294

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Emily V. Clawson | | | | 2. DATE OF DEATH MONTH 05 DAY 13 YEAR 90 | | 3. TIME OF DEATH 3:03 A.M. | |
| 4. SOCIAL SECURITY NUMBER 219-32-5391 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 72 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 1-27-1918 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore City - Eastpoint | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6411 Eastbourne Ave. | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Unknown | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Clarence Norris | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Viola Lance | | | |
| 19a. INFORMANT'S NAME (Type/Print) Glenn L. Clawson, Sr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6411 Eastbourne Ave. Balto., MD. 21224 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cemetery | | 20c. LOCATION — City or Town, State ROssville, Md. 21237 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd. Dundalk, Md. 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Oat Cell Lung CA ± Brain mets DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) May 16 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) Charles Oanna-Blankford 201 E. University Parkway Baltimore, MD 21218 Union Memorial Hosp | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 18539

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Van A. Crowe | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-13-90 | | 3. TIME OF DEATH 1:31PM M | |
| 4. SOCIAL SECURITY NUMBER 245-14-1250 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-17-1917 | |
| 8. BIRTHPLACE (State or Foreign Country) NORTH CAROLINA | | | | 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MARYLAND | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2520 FLEET STREET | |
| 10f. ZIP CODE 21224 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 YEARS College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WELDER | | 16b. KIND OF BUSINESS/INDUSTRY BETH STEEL | |
| 17. FATHER'S NAME (First, Middle, Last) ROBY C. CROWE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MAUDE STORY | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. ANNA BELLE CROWE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2520 FLEET ST. BALTO. MD. 21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS FOF FAITH | | 20c. LOCATION — City or Town, State BALTO. CO. MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles R. Kaczowski</i> | | | | 22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic cardiovascular disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic alcoholism | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-14-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frank Peretti, MD 111 Penn Street, Baltimore, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 13503



90 13297

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) Edward P. Cotter | | | | 2. DATE OF DEATH MONTH 5 DAY 12 YEAR 90 | | 3. TIME OF DEATH 1:40A M | |
| 4. SOCIAL SECURITY NUMBER 218-22-2392 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 61 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2-18-29 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH | | | | RESIDENCE OF DECEASED | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore City | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5510 Mayview Avenue | | | | 10f. ZIP CODE 21206 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machine Operator | | 16b. KIND OF BUSINESS/INDUSTRY American National Can Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last) John P. Cotter | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Mary Delss | | | |
| 19a. INFORMANT'S NAME (Type/Print) Anna Cotter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5510 Mayview Avenue Balto., Md. 21206 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lassahn Funeral Home | | | | 22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Balto., Md. 21236 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiogenic shock</u> | | | | | | | 2 hours |
| b. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL <input checked="" type="checkbox"/> INPATIENT <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA <input type="checkbox"/> OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 5/12/90 | | 28b. TIME OF INJURY 4:40A | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Steven P. Schuler MD | | | | 29c. LICENSE NUMBER 132389 | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Francis Scott Key Medical Center | | | | | | | |
| 31. DATE FILLED MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

90 13298

ELIZABETH M. DUNZWEILER

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Elizabeth M. Dunzweiler | | | | 2. DATE OF DEATH MONTH 5 - DAY 12 - YEAR 90 | | 3. TIME OF DEATH 7:15 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 578-62-5573 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11/11/05 | | 8. BIRTHPLACE (State or Foreign Country) Ellwood City, PA | | | |
| 9a. FACILITY NAME (If not Institution, give street and number) HERMAN WILSON HEALTH CARE CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg | | | 9c. COUNTY OF DEATH Montgomery | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Gaithersburg | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 401 Russell Avenue | | | | 10f. ZIP CODE 20877 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Home | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Wilbur — McGlade | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian — Reese | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) John Dunzweiler | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14225 Poplar Hill Rd. Darnestown, Md. 20874 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Funeral Service | | | 20c. LOCATION — City or Town, State Alexandria, Va. | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John B. Barber</i> | | | | 22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER F.H. P.O. Box 5038, Lqytovnsville, Md. 20882 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrest DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): Cerebral artery block DUE TO (OR AS A CONSEQUENCE OF): Hypertension | | | | | | | | Approximate Interval Between Onset and Death 8 4 yrs 4 yrs | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edmond J. Devlin</i> | | | | | | 29c. LICENSE NUMBER D33677 | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edmond J. Devlin, MD 19721 Executive Park Circle Herndon MD 20874 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Rodella</i> | | | | | | | |



John Doe

ALYAM

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13299

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) PEARL DUBROW | | | | 2. DATE OF DEATH MONTH 5 DAY 10 YEAR 90 | | 3. TIME OF DEATH 1518 M | |
| 4. SOCIAL SECURITY NUMBER 068-05-1583 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6/5/15 | |
| 9a. FACILITY NAME (If not institution, give street and number) SHADY GROVE ADVENTIST HOSP. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE | | 9c. COUNTY OF DEATH MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY MONTGOMERY | | 10c. CITY, TOWN OR LOCATION ROCKVILLE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1801 E. JEFFERSON ST. | | | | 10f. ZIP CODE 20852 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. D. WALDERS (daughter) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4704 Essex Ave., Chevy Chase, Md. 20815 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] 5.15.90 | | | | 22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BAORD, BALTO., MD. 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Adenocarcinoma of unknown Primary site DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death 3 mo. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER D29675 | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ralph Boccia MD 14808 PAVANAS LN Rockville | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 00501 00

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

A 118 52 48

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | REG. NO. | | | |
|--|--|---|--|---|---|---|---|--|--|
| DECEDENT'S NAME (First, Middle, Last) DORIS EDWARDS | | | | | | 2. DATE OF DEATH MONTH 05 DAY 12 YEAR 1990 | | 3. TIME OF DEATH 2:20 P.M. | |
| 4. SOCIAL SECURITY NUMBER 213-92-0465 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 64 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 12-20-25 | 8. BIRTHPLACE (State or Foreign Country) BALTO. | | | | |
| 9. RESIDENCE NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE CITY | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, MD. | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 859 HILLMAN CT. | | 10f. ZIP CODE 21202 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 4th GRADE | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED | | 15b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) GEORGE MITCHELL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIAN HARRIS | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) GERALDINE ASH | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 N. CENTRAL AVE. BALTO, MD. 21202 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST | | 20c. LOCATION — City or Town, State OWINGS MILLS | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gladys Warren | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST MYOCARDIAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 8 DAYS | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER RA Stum MD | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KEVIN A STIERER JOHNS HOPKINS HOSPITAL | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | | | |

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Page 2

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|--|--|---|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BERRY EISLER | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 12 1990 | | 3. TIME OF DEATH 10:10P M | | |
| 4. SOCIAL SECURITY NUMBER 220-30-2254 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05/12/1916 | | 8. BIRTHPLACE (State or Foreign Country) POLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | | 9c. COUNTY OF DEATH BALTIMORE | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 7207 CHALKSTONE DRIVE, A-2 | | | | |
| 10f. ZIP CODE 21208 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) HOUSEWIFE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY AT HOME | | | | |
| 17. FATHER'S NAME (First, Middle, Last) ZALIG FEFER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CHAVA STRUZZ | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MR. SOL EISLER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7207 CHALKSTONE DR., APT. A-2 BALTO., MD 21208 | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) AGUDAS ACHIM ANSHE SEARD | | 20c. LOCATION — City or Town, State ROSEDALE, MD | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jack H. Levinson</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIORESPIRATORY ARREST DUE TO (OR AS A CONSEQUENCE OF): b. RECURRENT METASTATIC MELANOMA OF VULVA DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. CERTIFY (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. H. Rosenstein MD</i> | |
| 29c. LICENSE NUMBER MD35464 | | | | | | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. H. Rosenstein MD | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>J. H. Rosenstein</i> | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) FREEMAN AARON (AARON FREEMAN) | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 9 90 | | 3. TIME OF DEATH 6:20am | |
| 4. SOCIAL SECURITY NUMBER 212-10-0661 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 09/24/02 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MARYLAND | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2909 FALLSTAFF RD., APT. 42 | |
| 10f. ZIP CODE 21209 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) EXECUTIVE | | 16b. KIND OF BUSINESS/INDUSTRY C&P TELEPHONE CO. | |
| 17. FATHER'S NAME (First, Middle, Last) JACOB FREEMAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH KRAMER | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. SOPHIA LOUISE FREEMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2909 FALLSTAFF RD., APT. 42 BALTIMORE, MD 21209 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE HEBREW | | 20c. LOCATION — City or Town, State REISTERSTOWN, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sol D Lewis</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIOGENIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): ACUTE MYOCARDIAL INFARCTION b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>K.P. Bhadha House officer, Sinai Hospital</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/9/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) K.P. Bhadha, House officer, Sinai Hospital of Baltimore | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | REG. NO. | | | |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | | | |
| Ophelia Funderburk | | | | MONTH 5 DAY 9 YEAR 90 | | | | 6:10 PM | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | | | |
| 213-36-2144 | | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 63 YRS. | | APR. 23, 1927 | | S. CAROLINA | | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | |
| Francis Scott Key Medical Ctr | | | | Baltimore | | | | | | | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | | | | | |
| Maryland | | Baltimore | | Dundalk | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| 101 Center Place Apt 212 | | 21222 | | USA | | | | | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) | | 14. RACE — American Indian, Black, White, etc. | | | | | |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| Elementary/Secondary (0-12) College (1-4 or 5+) | | Day Maid - Ret. | | Balto. Co. Bdged. | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | |
| Jim Ingram | | | | Laura | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| Mary Pitts | | | | 5615 Daywalt Ave. Balto. MD 21206 | | | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | | | | | | | |
| 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | Mt. Calvary Cemetery | | Brooklyn MD | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | |
| Shirley Adams | | | | MARSHALL W. JONES JR. R. H. PA 4101 Edmondson Ave. Baltimore MD 21229 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | 40 hours | | | |
| a. Right parietal Cerebral hemorrhage | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| b. Hypertension. | | | | | | | | 720 yrs | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| c. | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| d. | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| Obesity | | | | | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (Check only one) | | | | | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | | M | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) | | | | 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 5/9/90 | | | |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | | | | | |
| Brian Litt MD Chief Resident | | | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| Brian Litt MD; Francis Scott Key Medical Center, Baltimore, MD | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |
| MAY 16 1990 | | | | Jill Davidson | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13304

| | | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Edward William Fowler | | | | 2. DATE OF DEATH MONTH 5 DAY 12 YEAR 90 | | 3. TIME OF DEATH 5:45A M | | | | |
| 4. SOCIAL SECURITY NUMBER 219-18-0502 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4 16 23 | | 8. BIRTHPLACE (State or Foreign Country) MD | | |
| 9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson, MD | | | 9c. COUNTY OF DEATH Baltimore | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Dundalk | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 103 Centre-Place Apt. 220 | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Post Office | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edward Fowler | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude M. Evans | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Eleanor Fowler | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Centre-Place Apt. 220 Balto. Md. 21222 | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Cemetery | | | 20c. LOCATION — City or Town, State Baltimore Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Connolly Funeral Home | | | | 22. NAME AND ADDRESS OF FACILITY ConnollyFuneralHome 300MaceAve.21221 | | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cancer of prostate with metastasis DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Carla S. Alexander MD | | | | 29c. LICENSE NUMBER D 27087 | | 29d. DATE SIGNED (Month, Day, Year) 5/12/96 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carla S. Alexander, M.D.—Stella Maris Hospice—Dulaney Valley Rd.—Towson 21204 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | |

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90 13305

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) Emil H FUNK Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR May 15 1990 | | 3. TIME OF DEATH 8:30 A M | |
| 4. SOCIAL SECURITY NUMBER 212-01-8829 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7-13-12 | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hosp. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore County | | 9c. COUNTY OF DEATH Baltimore County | |
| 10a. STATE Md. | | | | 10b. CITY, TOWN OR LOCATION Balto. | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4022 Chestnut Rd. | | | | 10f. ZIP CODE 21220 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 1 | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Inspector | | 16b. KIND OF BUSINESS/INDUSTRY Balto. Gas & Electric | | | |
| 17. FATHER'S NAME (First, Middle, Last) Emil H. Funk | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Georgetta Owens | | | |
| 19a. INFORMANT'S NAME (Type/Print) Beatrice N. Funk | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4022 Chestnut Rd. Balto., Md. 21220 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cem. | | 20c. LOCATION — City or Town, State Balto., Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY John C. Miller Inc. 6415 Belair Rd. Balto., Md. 21206 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure, Biventricular failure - DUE TO (OR AS A CONSEQUENCE OF): End Stage Class IV DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal insufficiency, Coronary Artery Disease | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER NA | | 29d. DATE SIGNED (Month, Day, Year) May 5, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David Coates, MD 9000 Franklin Square Drive Baltimore, Maryland 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3166

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Charlie Grandy | | | | 2. DATE OF DEATH MONTH 5 DAY 13 YEAR 90 | | 3. TIME OF DEATH 6 37 P M | |
| 4. SOCIAL SECURITY NUMBER 224-20-8383 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 63 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 07-22-26 | | 8. BIRTHPLACE (State or Foreign Country) VIRGINIA | |
| 9a. FACILITY NAME (If not institution, give street and number) MERCY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 50 WEST WEST STREET | | | | 10f. ZIP CODE 21230 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1945-1946 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CHAUFFEUR | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) RAYFIELD A. GRANDY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CARRIE L. BOWE | | | |
| 19a. INFORMANT'S NAME (Type/Print) EDWARD GRANDY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6-D RIDGEBURY COURT (21207) | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VETERAN | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lynette K. Jones | | | | 22. NAME AND ADDRESS OF FACILITY BROWN/THOMPSON F.H. P.O. BOX 4433 (21223) | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death 1 day unclear |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Renal Failure DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER A. Schneider MD | | | | 29c. LICENSE NUMBER pending | | 29d. DATE SIGNED (Month, Day, Year) 5/13/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. Schneider MD 301 St Paul Balt MD 21202 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 5 MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson Registrar | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13307

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Mary Gordon</i> MARY K. GORDON | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 14 90 | | 3. TIME OF DEATH 6 15 A M | |
| 4. SOCIAL SECURITY NUMBER 216-10-0824 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 09 05 10 | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Sinai Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>MD</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6713 PARK HEIGHTS AVE, APT. 1A | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER | | 16b. KIND OF BUSINESS/INDUSTRY DRY CLEANING | | | |
| 17. FATHER'S NAME (First, Middle, Last) JACOB KARPA | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MIRIAM RESHOTKO | | | |
| 19a. INFORMANT'S NAME (Type/Print) DENNIS GORDON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2714 WILLOW GLEN DR. BALTO., MD 21209 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) CHIZUK AMUNO (ARLINGTON) | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jay Lewis</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 601C REISTERSTOWN RD. BALTO., MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>MI</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stephen O'Neil</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Sinai Hospital of Baltimore</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Jake Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13308

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CELIA H. GINSBURG | | | | 2. DATE OF DEATH MONTH 05 DAY 12 YEAR 90 | | 3. TIME OF DEATH 7:30 AM | |
| 4. SOCIAL SECURITY NUMBER 216-32-9019 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10, 13, 03 | |
| 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 7 SLADE AVE., APT. 719 | | | | 10f. ZIP CODE 21208 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 24 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRESIDENT | | 16b. KIND OF BUSINESS/INDUSTRY N. GINSBURG & SON | | | |
| 17. FATHER'S NAME (First, Middle, Last) LOUIS HALPERT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BELLE UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. LOIS SCHAPIRO | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 POMONA SOUTH, APT. 3 BALTO., MD 21208 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON (CHIZUK AMUNO) | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSER <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → GI BLEED DUE TO (OR AS A CONSEQUENCE OF): a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Deep vein Thrombosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D. | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Hassan-Charal, Sinai Hospital of Baltimore | | | | | | | |
| 31. MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LOUIS G. GRAUL Jr. | | | | 2. DATE OF DEATH MONTH 05 DAY 09 YEAR 90 | | 3. TIME OF DEATH 9:10 P M | |
| 4. SOCIAL SECURITY NUMBER 213-05-6343 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-5-19 | |
| 8. BIRTHPLACE (State or Foreign Country) MD | | | | 9a. FACILITY NAME (If not Institution, give street and number) Stella Maris Hospice | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson, MD | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Md. | | | |
| 10b. COUNTY Harford | | | | 10c. CITY, TOWN OR LOCATION Jarrettsville | | | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3808 Old Federal Hill Rd. | | | |
| 10f. ZIP CODE 21084 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES WW 11 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction Supt. Rtd. | | 16b. KIND OF BUSINESS/INDUSTRY J.Roland Dashiell & Sons | | | |
| 17. FATHER'S NAME (First, Middle, Last) Louis G. Gaul | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth N. Jones | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Audrey M. Gaul | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3808 Old Federal Hill Rd. Jarrettsville, Md. 21084 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Belair Memorial Gardens | | 20c. LOCATION — City or Town, State Bel Air, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE E.F. Lassahn | | | | 22. NAME AND ADDRESS OF FACILITY E.F. Lassahn Funeral home 11750 Belair Rd. Kingsville, Md. 21087 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Carla S. Alexander | | | | 29c. LICENSE NUMBER D 27087 | | 29d. DATE SIGNED (Month, Day, Year) 5/9/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carla S. Alexander, M.D.—Stella Maris Hospice—Dulaney Valley Rd.—Towson 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | 32. REGISTRAR'S SIGNATURE Johanna Davidson-Randall | | | | | |

MAY 16 1990

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WANDA E. GARFIELD | | | | | | 2. DATE OF DEATH MONTH DAY YEAR 5/6/90 | | | | 3. TIME OF DEATH 7:20P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 514-07-1557 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 1/24/16 | | 8. BIRTHPLACE (State or Foreign Country) OKLAHOMA | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 130 S. RITTERS LANE | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH OWINGS MILLS | | | | 9c. COUNTY OF DEATH | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION OWINGS MILLS | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 130 SOUTH RITTERS LANE | | | | | | 10f. ZIP CODE 21117 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY | | | | 16b. KIND OF BUSINESS/INDUSTRY SOCIAL SECURITY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) LEE BARNES | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) DORA BARNES HICKS | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MR. ROBERT GARFIELD (spouse) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 S. RITTERS LANE, OWINGS MILLS, Md. 21117 | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | | | 20c. LOCATION — City or Town, State | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> 5-15-90 | | | | 22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BOARD, BALTO., MD. 21201 | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Carcinoma of lung. DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Liver + Bone Metastasis. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | 29c. LICENSE NUMBER D25052 | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 20 Crossroads Drive, Suite 102, Owings Mills, MD 21117 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lillian Harden | | | | 2. DATE OF DEATH MONTH 05 DAY 14 YEAR 90 | | 3. TIME OF DEATH 3:04 A.M. | |
| 4. SOCIAL SECURITY NUMBER 212-22-4021 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 02/29/12 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE MD | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3002 Spaulding Ave | |
| 10f. ZIP CODE 21215 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY N/A | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES FRANCE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print) JOHN T. HARDEN JR. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 929 KEVIN ROAD (21229) | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shirley K. Jones</i> | | | | 22. NAME AND ADDRESS OF FACILITY BROWN/THOMPSON F.H. P.O. BOX 4433 (21223) | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MI Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Below Head |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stephen O'Neil</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sinai Hospital of Baltimore | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11661 00

REG. NO.

DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last) <i>Esther Herling</i> (ESTHER M. HERLING) | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>5/9/90</i> | | 3. TIME OF DEATH <i>7:15 P.M.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>218-07-2701A</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>86</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>02/02/04</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Balto, MD</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>Kwintale Geriatric Center & Hosp.</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Balto, Md</i> | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE <i>md</i> | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION <i>Balto Md 21215</i> | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>6930 Brookmill Rd Apt 2-B</i> | |
| 10f. ZIP CODE <i>21215</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | | | 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i> | | | |
| 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>BUYER</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY <i>HATS</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>LOUIS HERLING</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>RAY BROWN</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>MRS. BESSIE RICHMAN</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6 AMLEHT CT., APT. 2A BALTIMORE, MD 21215</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>HEBREW FRIENDSHIP</i> | | | |
| 20c. LOCATION — City or Town, State <i>BALTIMORE, MD</i> | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY <i>SOL LEVINSON & BROS, INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</i> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>SEPSIS</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <i>RECURRENT ASPIRATION</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>MULTIPLE INFECTED DEBRITUS ULCERS</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>OLD CEREBROVASCULAR ACCIDENT</i> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>DEMENTIA</i> <i>INABILITY TO SWALLOW</i> | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) <i>5-10-90</i> | | | |
| 28b. TIME OF INJURY <i>M</i> | | | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] ATTENDING MD</i> | | | | 29c. LICENSE NUMBER <i>130951</i> | | | |
| 29d. DATE SIGNED (Month, Day, Year) <i>5-10-90</i> | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>AT LUCCO 2434 W. BELLEVUE AVE. BALTO 21215</i> | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 16 1990</i> | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


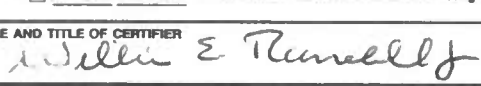

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ELIAS J. HARJANDREOU | | | | 2. DATE OF DEATH MONTH 05 DAY 12 YEAR 90 | | 3. TIME OF DEATH 12:05 A M | |
| 4. SOCIAL SECURITY NUMBER 187-14-1030 | | 5. SEX 1 M 2 F | | 6. AGE (yr. last birthday) 96 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-5-94 | |
| 8a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | | | 8b. CITY, TOWN OR LOCATION OF DEATH TOWSON | | 8c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 10e. STREET AND NUMBER 8416 Rocky Mt. Road | | | | 10f. ZIP CODE 21237 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 9th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bricklayer | | 16b. KIND OF BUSINESS/INDUSTRY Steel | | | |
| 17. FATHER'S NAME (First, Middle, Last) Demetrios Harjandreou | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Georgia | | | |
| 19a. INFORMANT'S NAME (Type/Print) James E. Harjandreou | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8416 Rocky Mt. Road, Baltimore, Md. 21237 | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Entombment | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Greek Orthodox Masoleum | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSE  | | | | 22. NAME AND ADDRESS OF FACILITY Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SILICOSIS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { a. DUE TO (OR AS A CONSEQUENCE OF): PNEUMONIA b. DUE TO (OR AS A CONSEQUENCE OF): CHF c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D15808 | | 29d. DATE SIGNED (Month, Day, Year) 5-12-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. WILLIAM RANDALL 6701 N. CHARLES STREET BALTIMORE, MARYLAND 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Neely James Sr. | | | | 2. DATE OF DEATH MONTH 5 - DAY 14 - YEAR 90 | | 3. TIME OF DEATH 7:34 P.M. | |
| 4. SOCIAL SECURITY NUMBER 60-13-80 | | 5. SEX M | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4/28/28 | |
| 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| 10a. STATE Md. | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Turners Station | |
| 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | | | | |
| 10e. STREET AND NUMBER 117 Chestnut St. | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 2 Married | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO | | 14. RACE — American Indian, Black, White, etc. Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sanitation Worker | | 15b. KIND OF BUSINESS/INDUSTRY Sanitation Dept. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Ed James | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Rice | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Seareese James | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Chestnut St. Baltimore, Md. 21222 | | | |
| 20a. METHOD OF DISPOSITION 2 Burial 3 Cremation 4 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. LOCATION — City or Town, State Balto., Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James A. Morton | | | | 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons 1701 Laurens St. Balto., Md. 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia | | | | | | | 4 days |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | 1-2 yrs |
| a. DUE TO (OR AS A CONSEQUENCE OF): Head and Neck Cancer | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER A. Fitzgerald MD | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. Fitzgerald MD ESK Medical Center 4940 Eastern Ave. Balto MD 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE A. Fitzgerald MD | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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21-51-60



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) KEITH THOMAS JOHNSON | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 8:32 P M | |
| 4. SOCIAL SECURITY NUMBER 228 223 714 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 11, 1924 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE MD | | | |
| 10b. COUNTY Baltimore | | | | 10c. CITY, TOWN OR LOCATION Essex | | | |
| 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | 10e. STREET AND NUMBER 1201 Middle way Rd 1A | | | |
| 10f. ZIP CODE 21220 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Welder | | 16b. KIND OF BUSINESS/INDUSTRY Welding | | | |
| 17. FATHER'S NAME (First, Middle, Last) Jesse C. Johnson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Aranita Sue Mason | | | |
| 19a. INFORMANT'S NAME (Type/Print) Wanda Loudermilk | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1201 Middleway Rd Essex MD 21220 | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory | | 20c. LOCATION City or Town, State Balto MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | | | 22. NAME AND ADDRESS OF FACILITY 1211 Chesaco Ave. Rosedale MD 21237 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-12-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita A. Korell, M.D., Assistant 111 Penn Street, Baltimore, MD 21201 vl | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Leroy Kidwell | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH 1202 A.M. | |
| 4. SOCIAL SECURITY NUMBER 212-12-7844 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6-3-21 | |
| 9a. FACILITY NAME (If not institution, give street and number) Mercy Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| 10a. STATE MD. | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore 21202 | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 230 S. ALBERMARK ST. | | 10f. ZIP CODE 21202 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 8+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Police Officer | | 16b. KIND OF BUSINESS/INDUSTRY LAW ENFORCEMENT | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Kidwell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Viola Seymour | | | |
| 19a. INFORMANT'S NAME (Type/Print) EUGENE Kidwell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 OSBORNE AVE Catonsville 21228 MD. | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Redeemer Cem | | 20c. LOCATION — City or Town, State Baltimore MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | | | 22. NAME AND ADDRESS OF FACILITY 322 S. HIGH ST. BALTO 21202 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal Failure DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER A Schneider MD | | | | 29c. LICENSE NUMBER pending | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A Schneider 301 St Paul Baltimore MD 21202 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) AUGUST FREDERICK KOESTER | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH 0100 M | |
| 4. SOCIAL SECURITY NUMBER 214-01-1478 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 7 1917 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 1315 Dorsey Ave. | | 9b. CITY, TOWN OR LOCATION OF DEATH Essex | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Md. | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Essex | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 1315 Dorsey Ave. | |
| 10f. ZIP CODE 21221 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 6+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY Local 11 | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Koester | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lena Schipper | | | |
| 19a. INFORMANT'S NAME (Type/Print) Charles Koester | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2925 Alcorbury Rd. Abington Md. 21009 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cemetery | | | |
| 20c. LOCATION — City or Town, State Rossville Md. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Connelly Funeral Home | | | |
| 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home 300 Ace Ave. 21221 | | | | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute intracerebral hemorrhage DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER J. Crossan Donovan | | | |
| 29c. LICENSE NUMBER 207632 | | | | 29d. DATE SIGNED (Month, Day, Year) 5-14-90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Crossan Donovan, 2112 DUNDALK AVE., BALTO., MD. 21222 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE J. Crossan Donovan | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|---|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) BERNETTE LOVELESS | | | | 2. DATE OF DEATH MONTH DAY YEAR 05-14-90 | | 3. TIME OF DEATH 12:10 P M | |
| 4. SOCIAL SECURITY NUMBER 216-01-6434 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 79 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 03-07-11 | | 8. BIRTHPLACE (State or Foreign Country) BALTO. | |
| 9a. FACILITY NAME (If not institution, give street and number) EVERGREEN NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, CITY | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 39 BENONI CIR. | | | | 10f. ZIP CODE 21220 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th GRADE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH B. DICKSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY LOU BROOKS | | | |
| 19a. INFORMANT'S NAME (Type/Print) CYNTHIA PHILLIPS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39 BONONI CIR. BALTO, MD. 21220 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) VOSHELL MEMORIAL GARDENS | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>B. L. L. L. L. L.</i> | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive Heart Failure</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Renal Failure</i> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Recurrent Pneumonia</i> <i>Recurrent Urinary Infections</i> <i>Multiple Strokes</i> | | | | | | | Approximate Interval Between Onset and Death <i>weeks</i> <i>months</i> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Albert B. Bradley M.D.</i> | | | | 29c. LICENSE NUMBER D00426 | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4900 BELAIR ROAD BALTIMORE, MARYLAND 21206 ALBERT B. BRADLEY, M.D. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>J. Davidson</i> | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

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TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) THOMPSON LELIA LELIA | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 14 90 | | 3. TIME OF DEATH 9:52 P.M. | |
| 4. SOCIAL SECURITY NUMBER 114-09-8509 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03/21/96 | |
| 8. BIRTHPLACE (State or Foreign Country) Va. | | | | 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE MD | | 10b. COUNTY BALTIMORE | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 4808 LAUREL AVENUE | |
| 10f. ZIP CODE 21215 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress | | 16b. KIND OF BUSINESS/INDUSTRY Garment | |
| 17. FATHER'S NAME (First, Middle, Last) Frank Hunter | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Capitolia Howard | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Jeanne Charleston | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3402 Bateman Avenue Balto., Md. 21216 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial | | 20c. LOCATION — City or Town, State Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James A. Morton | | | | 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → EXSANGUINATION | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| GASTROINTESTINAL BLEED | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ABDOMINAL AORTIC ANEURYSM ANEMIA CHRONIC ATRIAL FIBRILLATION | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Belinger MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BEKRINGER MD SINAI HOSPITAL | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE John [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13321

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) GLORIA LIPPMAN | | | | 2. DATE OF DEATH MONTH 05 DAY 13 YEAR 90 | | 3. TIME OF DEATH 11:40 AM | |
| 4. SOCIAL SECURITY NUMBER 213-26-0794 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12 12 27 | |
| 8. BIRTHPLACE (State or Foreign Country) NEW YORK | | | | 9a. FACILITY NAME (If not institution, give street and number) Simon Hospital of Baltimore | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore MD | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 3317 OLD POST DR. | |
| 10f. ZIP CODE 21208 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) 1 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last) CARL SHAPIRO | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SADIE FRANKEL | | | |
| 19a. INFORMANT'S NAME (Type/Print) SYDNEY M. LIPPMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3317 OLD POST DR. BALTIMORE, MD 21208 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____ | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) CHIZUK AMUNO (ARLINGTON) | | 20c. LOCATION — City or Town, State BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joel D. Lewis</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Metastatic Breast Carcinoma | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Pulm edema | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. _____ | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. _____ | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M _____ | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER DR SADHANA SHAH | | | | 29c. LICENSE NUMBER Beper 2343 | | 29d. DATE SIGNED (Month, Day, Year) 5/13/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Hendall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1584 05

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13322

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RAYMOND A. LUMPKIN, SR. | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 12 1990 | | 3. TIME OF DEATH 2:20 A.M. | |
| 4. SOCIAL SECURITY NUMBER 219 22 5316 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06-22-23 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH - | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 10e. STREET AND NUMBER 2025 Sue Creek Drive | | | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 10th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Realtor | | 16b. KIND OF BUSINESS/INDUSTRY Real Estate | | | |
| 17. FATHER'S NAME (First, Middle, Last) Melvin Lumpkin | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Carrie Lumpkin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2025 Sue Creek Drive, Baltimore, Md. 21221 | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Chad S. Matthews | | | | 22. NAME AND ADDRESS OF FACILITY Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. severe refractory C.H.F. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. INSULIN DEPENDANT DIABETES MELITUS DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHOLERA PHLEBITIS | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER P. Shah, M.D. Intern. | | | | 29c. LICENSE NUMBER - | | 29d. DATE SIGNED (Month, Day, Year) 05/12/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Pradip Shah, M.D. Good Samaritan Hosp. Baltimore MD. | | | | | | | |
| 31. DATE OF DEATH (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE J. Davidson | | | |

25071 400

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | REG. NO. | | | |
|--|--|--|--|--|--|--|--|---|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | | | |
| Donald LANNON SR. | | | | May 14 1990 | | | | 3:30 P M | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | | | |
| 216-28-6343 | | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 58 YRS. | | NOV. 30 1931 | | Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | |
| Franklin Square Hospital | | | | Rossville | | | | Baltimore County | | | |
| 10a. STATE | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | | | |
| Md. | | | | Baltimore | | Middle River | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | |
| 536 Cole Lane | | | | 21220 | | USA | | | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | 14. RACE — American Indian, Black, White, etc. | | | | | |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | Specify: white | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| Elementary/Secondary (9-12) College (1-4 or 5 +) | | | | Driver | | | | Baltimore County | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | |
| Francis X. Lannon | | | | Dorothy M. Whitley | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| Evelyn Lannon | | | | 536 Cole Lane Baltimore Maryland 21220 | | | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | | | | | | | |
| 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | Holly Hill Cemetery | | Baltimore MD. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | |
| Connelly Funeral Home | | | | ConnellyFuneralHome 300MaceAve. 21221 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Anterior Inferior Myocardial Infarction | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): b. Pulmonary Edema | | | | | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. Congestive Heart Failure | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? | | | |
| | | | | | | | | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| | | | | | | | | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (Check only one) | | | | | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | | M | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) | | | | 29b. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29c. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 1 <input type="checkbox"/> CERTIFYING PHYSICIAN 2 <input type="checkbox"/> MEDICAL EXAMINER | | | | | | | | | | | |
| 29d. SIGNATURE AND TITLE OF CERTIFIER | | | | 29e. LICENSE NUMBER | | | | 29f. DATE SIGNED (Month, Day, Year) | | | |
| M. Marshall DO | | | | NA | | | | May 14, 1990 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| M. Marshall, DO 9000 Franklin Square Drive Baltimore, Maryland 21237 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |
| MAY 16 1990 | | | | John Davidson-Randall | | | | | | | |

00 10000

90 13324

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WALTER JACKSON LANGFORD | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH 0930 M | |
| 4. SOCIAL SECURITY NUMBER 262-16-1206 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 25 1921 | |
| 9a. FACILITY NAME (If not institution, give street and number) 7415 Holabird Ave. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Dundalk | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Dundalk | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7415 Holabird Ave. | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY School Board | | | |
| 17. FATHER'S NAME (First, Middle, Last) William K. Langford | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Georgia Fulgham | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ruth Langford | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7415 Holabird Ave. Baltimore Md. 21222 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Inc. | | 20c. LOCATION — City or Town, State Baltimore Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Connelly Funeral Home</i> | | | | 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Dundalk 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hand gun wound of head DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 5-14-90 | | 28b. TIME OF INJURY 0930 M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED Self inflicted hand gun wound | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 7415 Holabird Ave., Balto., Md | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER J.C. Donovan M.D. | | | | | |
| | | 29c. LICENSE NUMBER D07632 | | 29d. DATE SIGNED (Month, Day, Year) 5-14-90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J.C. Donovan, M.D. 2112 DUNDALK AVE., BALTO., MD. 21222 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13325

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lange, Margaret | | | | 2. DATE OF DEATH MONTH 5 DAY 12 YEAR 90 | | | | 3. TIME OF DEATH 7:51 PM | |
| 4. SOCIAL SECURITY NUMBER 228-62-5575 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-08-07 | | 8. BIRTHPLACE (State or Foreign Country) USA-NEW JERSEY | |
| 9a. FACILITY NAME (If not institution, give street and number) FAIRHAVEN 7200 Third Ave. Sykesville | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Sykesville Maryland | | | | 9c. COUNTY OF DEATH Carroll | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Carroll | | 10c. CITY, TOWN OR LOCATION Sykesville, Maryland | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7200 Third Ave. Sykesville, Maryland | | | | 10f. ZIP CODE 21784 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Richard Egan Kersey | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian E. Brumeroph | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lillian E. Brumeroph | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] 5-15-90 | | | | 22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BAORD, BALTO., MD. 21201 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic Cardiovascular diseases DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death minutes 10 years | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] MD | | | | 29c. LICENSE NUMBER D34849 | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM TAN MD 7200 3rd Ave Sykesville MD 21784 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Ray D. Lee | | | | | | 2. DATE OF DEATH MONTH DAY YEAR May 13, 1990 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 201-24-1121 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 31, 1931 | | 8. BIRTHPLACE (State or Foreign Country) Pa. | |
| 9a. FACILITY NAME (If not institution, give street and number) 8713 School Road | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 8713 School Road | | | | 10f. ZIP CODE 21234 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cabinet Maker | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Clarence Lee | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Irene Steckman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Leona Lee | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8713 School Road Baltimore, Md. 21234 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood | | 20c. LOCATION — City or Town, State Baltimore, Maryland 21234 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Gladden <i>James F. Gladden</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Inc. 5305 Harford Rd. 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ① chronic wasting syndrome (weight loss, fatigue) > months ② progressive encephalitis Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST → ③ RETROVIRAL INFECTION. ~ 6 years d. | | | | | | | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. w/o pneumococcal pneumonia | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO (refused) | | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER David W. Oldach MD | | | | | | 29c. LICENSE NUMBER D37923 | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David Oldach MD 600 Wolfe Street Baltimore, Md. | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | REG. NO. | |
|---|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| 1. DECEDENT'S NAME (First, Middle, Last) HERBERT G. LINDLAW, SR. | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 13 90 | |
| 4. SOCIAL SECURITY NUMBER 212-01-5621 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) April 10, 1905 | | 8. BIRTHPLACE (State or Foreign Country) New York | | 3. TIME OF DEATH 10:20 A M | |
| 9a. FACILITY NAME (If not institution, give street and number) BALTIMORE COUNTY GEN. HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH RANDALLSTOWN | | 9c. COUNTY OF DEATH BALTO. | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Reisterstown | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 193 Shetland Circle | | 10f. ZIP CODE 21136 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Pressman | | 16b. KIND OF BUSINESS/INDUSTRY The Baltimore Sunpaper | | 17. FATHER'S NAME (First, Middle, Last) Frederick Lindlaw | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | | 19a. INFORMANT'S NAME (Type/Print) Ellen F. Lindlaw | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 193 Shetland Circle, Reisterstown, Md. 21136 | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem.Gdns.5/16/90 | | 20c. LOCATION — City or Town, State Timonium, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald E. Schuler</i> | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc., 1050 York Rd. Towson, Md. 21204 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Cardiorespiratory Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Chronic Lymphocytic Leukemia (new)</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jay Stephen MAREOL</i> | | 29c. LICENSE NUMBER 008029 | |
| 29d. DATE SIGNED (Month, Day, Year) 5/13/90 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jay Stephen MAREOL 15 W. 70 F. Painter's Mill Rd. Camp Hill, Md 21117 | | 31. DATE FILED (Month, Day, Year) MAY 16 1990 | |
| 32. REGISTRAR'S SIGNATURE <i>J. H. Anderson</i> | | | | | |

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ELISE H. LARSON | | | | 2. DATE OF DEATH MONTH 5 DAY 12 YEAR 90 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 555-07-2833 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8-22-06 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) St. Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 1713 Edgewood Rd. Apt. B | |
| 10f. ZIP CODE 21234 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | |
| 17. FATHER'S NAME (First, Middle, Last) Edmund Reuber | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Snyder | | | |
| 19a. INFORMANT'S NAME (Type/Print) Marie Frew | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6920 Donachie Rd. Baltimore, Md. 21234 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Hillside Cemetery 5-16-90 | | 20c. LOCATION — City or Town, State Allentown, PA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Acute cardiac arrest | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Coronary artery | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. ASCVD | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. Atrial fibrillation | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus Ch. renal insuff. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DCA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | | | | |
| 28b. TIME OF INJURY M | | | | | | | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Edgar M. M.D. | | | | | | | |
| 29c. LICENSE NUMBER D10699 | | | | | | | |
| 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lee Robbins M.D. 1205 York Rd. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | | | | |
| 32. REGISTRAR'S SIGNATURE  | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|---|--|--|---|--|---|--|---|----|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) SYDNEY MALESON | | | | 2. DATE OF DEATH MONTH DAY YEAR May 12 1990 | | 3. TIME OF DEATH 2:30 P.M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-01-2569 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6/8/10 | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) CHERRYWOOD NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH REISTERSTOWN | | 9c. COUNTY OF DEATH BALTIMORE | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION REISTERSTOWN | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 149 CHESTNUT HILL LANE | | | | 10f. ZIP CODE 21136 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRINTER | | 16b. KIND OF BUSINESS/INDUSTRY PRINTING | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) HYMAN MALESON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CLARA YOUNG | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MR. RONALD MALESON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 149 CHESTNUT HILL LA. REISTERSTOWN, MD 21136 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BETH EL MEMORIAL PARK | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MD | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joel D Lewis | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Aortic Dissection Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <table border="0"> <tr> <td rowspan="4"> a. Chronic obstructive Pulmonary Disease b. Emphysema </td> <td> DUE TO (OR AS A CONSEQUENCE OF): c. Peptic Ulcer Disease </td> </tr> <tr> <td> d. </td> </tr> </table> | | | | | | | a. Chronic obstructive Pulmonary Disease b. Emphysema | DUE TO (OR AS A CONSEQUENCE OF): c. Peptic Ulcer Disease | d. | Approximate Interval Between Onset and Death | |
| a. Chronic obstructive Pulmonary Disease b. Emphysema | DUE TO (OR AS A CONSEQUENCE OF): c. Peptic Ulcer Disease | | | | | | | | | | |
| | d. | | | | | | | | | | |
| | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peptic Ulcer Disease | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER GARY A MANKO MD | | | | 29c. LICENSE NUMBER D25062 | | 29d. DATE SIGNED (Month, Day, Year) 5-13-1990 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GARY A MANKO MD, 11 E Chestnut Hill Ln, REISTERSTOWN, MD 21136 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE John D. ... | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Beatrice Myrick | | | | 2. DATE OF DEATH MONTH 05 DAY 13 YEAR 90 | | 3. TIME OF DEATH 3:35 P M | |
| 4. SOCIAL SECURITY NUMBER 214-26-6446 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 60 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 09/12/29 | | 8. BIRTHPLACE (State or Foreign Country) | |
| 9a. FACILITY NAME (If not institution, give street and number) Univ. of Maryland Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| 10a. STATE MD | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 2071 Druid Park Drive Baltimore | | | | 10f. ZIP CODE 21211 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) GRAY, William Rufus | | | | 18. MOTHER'S NAME (First, Middle, Maiden, Surname) Moore, Nina | | | |
| 19a. INFORMANT'S NAME (Type/Print) LENA HARRINGTON (daughter) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Anatomy Board of Maryland | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | | | 22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BAORD, BALTO., MD. 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic Obstructive Pulmonary Disease Exacerbation DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Maria M. Garcia MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/13/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIA M. Garcia - Univ. of Maryland Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13331

| | | | | | | | | | |
|---|--|--|--|---|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT L. MARTIN | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 13 90 | | 3. TIME OF DEATH M 90 | | | |
| 4. SOCIAL SECURITY NUMBER 297-07-7716 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-21-10 | | 8. BIRTHPLACE (State or Foreign Country) Ohio | |
| 9a. FACILITY NAME (If not institution, give street and number) 853 Kellogg Rd. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Lutherville | | | 9c. COUNTY OF DEATH Baltimore | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Lutherville | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 853 Kellogg Rd. | | | | 10f. ZIP CODE 21093 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 yrs | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) District Manager | | | 18b. KIND OF BUSINESS/INDUSTRY Goodyear Tire and Rubber | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Warren Martin | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Zimmerman | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Regina Martin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 853 Kellogg Rd. Lutherville, Md. 21093 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley 5-15-90 | | | 20c. LOCATION — City or Town, State Timonium, Md. | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Therese D. Lundy</i> | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic lung cancer to liver DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: 2 mon. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles A. Padgett M.D.</i> | | | | 29c. LICENSE NUMBER D15546 | | 29d. DATE SIGNED (Month, Day, Year) 5-14-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles A. Padgett M.D. 5601 Loch Raven Blvd. | | | | | | | | | |
| 31. DATE MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) William James Mc GAHAN | | | | 2. DATE OF DEATH MONTH 5 DAY 10 YEAR 90 | | 3. TIME OF DEATH 12:30 | |
| 4. SOCIAL SECURITY NUMBER 213-18-6683 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6/13/21 | |
| 8. FACILITY NAME (If not institution, give street and number) Union Hospital 106 Bow St | | | | 9b. CITY, TOWN OR LOCATION OF DEATH ELKTON MD | | 9c. COUNTY OF DEATH Cecil | |
| 10a. STATE MD | | | | 10b. COUNTY Cecil Co | | 10c. CITY, TOWN OR LOCATION ELKTON MD | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 103 MALLARD COURT ELKTON MD | | | |
| 10f. ZIP CODE 21921 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRAINEE II RET. DRIVER LICENCE | | 16b. KIND OF BUSINESS/INDUSTRY DEPT. MOTOR VEHICLES | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM J. MCGAHAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) HELEN LESLIE | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARGARET S. MCGAHAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 MALLARD CT., ELKTON, MD. 21921 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 5-15-90 | | | | 22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BOARD, BALTO., MD. 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → UREMIA a. DUE TO (OR AS A CONSEQUENCE OF): END STAGE RENAL FAILURE b. DUE TO (OR AS A CONSEQUENCE OF): DIABETES (DIABETIC NEPHROSIS) c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Thomas E. Finckel MD | | 29c. LICENSE NUMBER D.32395 | |
| 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas E. Finckel MD ELKTON MD | | 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20-21 00

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

REG. NO.



BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ISADORE NARUN | | | | 2. DATE OF DEATH MONTH 5 DAY 12 YEAR 1990 | | | | 3. TIME OF DEATH 7 AM | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 22-12-5766 | | | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7/31/04 | | 8. BIRTHPLACE (State or Foreign Country) LITHUANIA | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH 1 | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 6810 PARK HEIGHTS AVE., APT. 408 | | | | | | 10f. ZIP CODE 21215 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PROPRIETOR | | | | 16b. KIND OF BUSINESS/INDUSTRY GEN. MERCHANDISE | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) MORRIS NARUN | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LEAH MAIER | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) DR. MARTIN N. NARUN | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2215 SHEFFLIN CT. BALTIMORE, MD 21209 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BETH TFILOH | | | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CHRONIC RENAL FAILURE Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST HYPERTENSION | | | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANEMIA | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M. Shukla PHYSICIAN | | | | | | | | 29c. LICENSE NUMBER MS 9307 | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MANGESH SHUKLA, SINAI HOSPITAL, BALTIMORE 21215 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BERNICE M. NEUMAN | | | | 2. DATE OF DEATH MONTH 5 DAY 12 YEAR 90 | | 3. TIME OF DEATH 4:30 P M | |
| 4. SOCIAL SECURITY NUMBER 213-36-6797 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 49 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 24 1940 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 3927 Mt. Pleasant | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE Md. | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 3927 Mt. Pleasant Ave. | |
| 10f. ZIP CODE 21224 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 9th | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Richard A Dovel | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Doris Collison | | | |
| 19a. INFORMANT'S NAME (Type/Print) Frederick Neuman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3927 Mt. Pleasant Ave. Balto. Md. 21224 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Cemetery | | 20c. LOCATION — City or Town, State Baltimore Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Connelly Funeral Home</i> | | | | 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home 300 Mac Ave. 21221 | | | |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Exsanguination due to penetrating duodenal ulcer DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ann M. Dixon</i> | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-13-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann M. Dixon, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 vl | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randell</i> | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY NAOMI OSTER | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH 1:30 P.M. M | |
| 4. SOCIAL SECURITY NUMBER 220-46-3968 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6/23/07 | |
| 9a. FACILITY NAME (If not institution, give street and number) 2712 Huron Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2712 Huron Street | | 10f. ZIP CODE 21230 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (1-4 or 5+) College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY | | 17. FATHER'S NAME (First, Middle, Last) Albert J. Kaufman | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie E. Bergen | | | | 19a. INFORMANT'S NAME (Type/Print) Edwin W. Oster, Sr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2712 Huron Street Baltimore, Md 21230 | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raymond Peterson</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore Md. 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| e. <i>respiratory arrest</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| f. <i>myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| g. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| h. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marie A. Dobyns</i> | | | | 29c. LICENSE NUMBER D29923 | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marie Dobyns 2822 Hollins Ferry Road Baltimore, Md 21230 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13336

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|---|---|---------------------------------|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) James E. Powell | | | | 2. DATE OF DEATH MONTH: April DAY: 29 YEAR: 1990 | | 3. TIME OF DEATH 8:39 A.M. | |
| 4. SOCIAL SECURITY NUMBER 218-14-2025 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 68 YRS. | IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN. | IF UNDER 24 HRS. HOURS: MIN. | 7. DATE OF BIRTH (Month, Day, Year) 2/23/22 | |
| 9a. FACILITY NAME (If not institution, give street and number) 6001 E. Pines Dr. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Riverdale | | 9c. COUNTY OF DEATH Prince George's | |
| 10a. STATE Md. | | | | 10b. COUNTY P.G. | | 10c. CITY, TOWN OR LOCATION Riverdale | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 6001 E. Pines Dr. | | | | 10f. ZIP CODE 20737 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY Auto Dealer | | | |
| 17. FATHER'S NAME (First, Middle, Last) John W. Powell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Neil | | | |
| 19a. INFORMANT'S NAME (Type/Print) Josephine Powell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 above | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lincoln Mem. Cem. 5/3/90 | | 20c. LOCATION — City or Town, State Suitland, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gary H. Pratt | | | | 22. NAME AND ADDRESS OF FACILITY H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sudden Cardio Pulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Lung Carcinoma DUE TO (OR AS A CONSEQUENCE OF): c. Metastatic Brain Cancer DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death Sudden |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. — Heart Nutrition | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M: 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Suresh K. Gupta, M.D. | | | | 29c. LICENSE NUMBER D-32332 | | 29d. DATE SIGNED (Month, Day, Year) 5/21/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Suresh K. Gupta, M.D. 9801 Georgia Ave., Silver Spring, Md. 20902 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2025 10

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) David Parker | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 6 90 | | 3. TIME OF DEATH 12:56 A ^M | |
| 4. SOCIAL SECURITY NUMBER 219-84-6996 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 27 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5/15/62 | |
| 8. BIRTHPLACE (State or Foreign Country) Md. | | | | 9a. FACILITY NAME (If not institution, give street and number) Prince George's General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Cheverly | |
| 9c. COUNTY OF DEATH Prince George's | | | | 10a. STATE Md. | | 10b. COUNTY P.G. | |
| 10c. CITY, TOWN OR LOCATION Landover | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 7928 Sheriff Rd. | |
| 10f. ZIP CODE 20785 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Custodian | | 16b. KIND OF BUSINESS/INDUSTRY Apt. Bldg. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles W. Parker | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Gloria Maynard | | | |
| 19a. INFORMANT'S NAME (Type/Print) Gloria M. Parker | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 above | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Mem. Park 5/12/90 | | 20c. LOCATION — City or Town, State Landover, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry M. Pratt</i> | | | | 22. NAME AND ADDRESS OF FACILITY H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Two stab wounds to left chest and abdomen DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 5/5/90 | | 28b. TIME OF INJURY 10:30P ^M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED Subject stabbed | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) Seat Pleasant, MD 6800 Blk. Central Avenue | | 28f. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) street | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia C. Goodin</i> | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5/6/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julia C. Goodin, M.D. - Assistant 111 Penn St. Balto. MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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90 13338

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|--|--|---|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>MARK S. PRICE</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>5-14-1990</i> | | 3. TIME OF DEATH <i>10:25 AM</i> | | |
| 4. SOCIAL SECURITY NUMBER <i>212-22-7427</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>84</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>5-18-05</i> | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Baltimore County General</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTO. MD.</i> | | 9c. COUNTY OF DEATH <i>BALTO.</i> | | |
| RESIDENCE OF DECEDENT | | | | | | | | |
| 10a. STATE <i>MD.</i> | | 10b. COUNTY <i>BALTIMORE</i> | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER <i>801 WINTERS LANE APT. 230</i> | | | | 10f. ZIP CODE <i>21228</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i> | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th Gr.</i> College (1-4 or 5+) <i>SALES PERSON / CLERK</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>SALES PERSON / CLERK</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>MAY CO.</i> | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>John Vibock</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Anne Hackel</i> | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>NORMAN PRASHINSKY</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>409 SACRED HT. LANE BALTO. MD. 21136</i> | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>LODEN PARK CEMETERY</i> | | 20c. LOCATION — City or Town, State <i>BALTO. MD.</i> | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen Vickers</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>EDWARD J. WEBER F.H. 5311 EDMONDSON AVE</i> | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiogenic Shock</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <i>Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| c. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>William J. Churney M.D.</i> | | | | 29c. LICENSE NUMBER <i>P29085</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>5/14/90</i> | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Allen J. Churney M.D. Baltimore County General Hosp.</i> | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 16 1990</i> | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The purpose of this document is to provide information regarding the status of the project and the progress of the work. The information is intended for the use of the project manager and the project team.

2. The project is currently in the planning phase. The project manager is working on the project plan and the project team is working on the project charter. The project manager is also working on the project budget and the project team is working on the project schedule.

3. The project is expected to be completed by the end of the year. The project manager is working on the project plan and the project team is working on the project charter. The project manager is also working on the project budget and the project team is working on the project schedule.

4. The project is currently in the planning phase. The project manager is working on the project plan and the project team is working on the project charter. The project manager is also working on the project budget and the project team is working on the project schedule.

5. The project is currently in the planning phase. The project manager is working on the project plan and the project team is working on the project charter. The project manager is also working on the project budget and the project team is working on the project schedule.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13339

| | | | | | | | | | | | |
|---|--|---|--|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>JAMES I. QUEEN</i> | | | | 2. DATE OF DEATH MONTH <i>6</i> DAY <i>13</i> YEAR <i>90</i> | | 3. TIME OF DEATH <i>7.05 P.</i> | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>579-03-0138</i> | | 5. SEX <i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>82</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>11/13/07</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Cap. Hgts., Md</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>So. Maryland Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>CLINTON</i> | | | 9c. COUNTY OF DEATH <i>P. G. County</i> | | | | |
| 10a. STATE <i>Md.</i> | | 10b. COUNTY <i>P.G.</i> | | 10c. CITY, TOWN OR LOCATION <i>Capitol Hgts.</i> | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER <i>1405 Rollins Ave.</i> | | | | 10f. ZIP CODE <i>20743</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | |
| 11. MARITAL STATUS <i>1</i> <input type="checkbox"/> Never Married <i>2</i> <input checked="" type="checkbox"/> Married <i>3</i> <input type="checkbox"/> Widowed <i>4</i> <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. <i>Black</i> | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>5th</i> | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Maintenance</i> | | 15b. KIND OF BUSINESS/INDUSTRY <i>D.C. Transit</i> | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Stephen Queen</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Sophie Davidge</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Goldie Francis</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5622 Central Ave., S.E., Wash., D.C. 20019</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION <i>1</i> <input checked="" type="checkbox"/> Burial <i>2</i> <input type="checkbox"/> Cremation <i>3</i> <input type="checkbox"/> Removal from State <i>4</i> <input type="checkbox"/> Donation <i>5</i> <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Harmony Mem. Park 5/17/90</i> | | 20c. LOCATION — City or Town, State <i>Landover, Md.</i> | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Grate</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E.</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis, secondary to Klebsiella pneumonia</i> Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>Diabetic Ketoacidosis, precipitated by pneumonia</i> <i>Acute renal failure secondary sepsis</i> | | | | | | | | Approximate Interval Between Onset and Death <i>1wk</i> <i>1wk.</i> <i>1wk</i> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arteriosclerotic peripheral vascular disease with</i> <i>40 old cerebral vascular accidents</i> <i>Dementia</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <i>1</i> <input checked="" type="checkbox"/> Inpatient <i>2</i> <input type="checkbox"/> ER/Outpatient <i>3</i> <input type="checkbox"/> DOA OTHER: <i>4</i> <input type="checkbox"/> Nursing Home <i>5</i> <input type="checkbox"/> Residence <i>6</i> <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <i>1</i> <input checked="" type="checkbox"/> Natural <i>5</i> <input type="checkbox"/> Pending Investigation <i>2</i> <input type="checkbox"/> Accident <i>6</i> <input type="checkbox"/> Could not be determined <i>3</i> <input type="checkbox"/> Suicide <i>4</i> <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <i>1</i> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>William T. Tanner MD</i> | | | | 29c. LICENSE NUMBER <i>D 35206</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>MAY 14 1990</i> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>William T. TANNER MD 11701 Livingston RD, Ft. WASHINGTON, MD 20744</i> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 16 1990</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Johanna Anderson-Randall</i> | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|---|--|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Steven L. Robinson | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 3:35pm | | |
| 4. SOCIAL SECURITY NUMBER 577-70-4347 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 38 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05-24-51 | | |
| 9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY | | 9c. COUNTY OF DEATH PRINCE GEORGES | | |
| 10a. STATE Md. | | 10b. COUNTY P.G. | | 10c. CITY, TOWN OR LOCATION Chapel Oaks | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 1415 Early Oaks Ln. | | | | 10f. ZIP CODE 20743 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 10th | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Driver | | 17. KIND OF BUSINESS/INDUSTRY Trucking | | | | |
| 17. FATHER'S NAME (First, Middle, Last) James E. Robinson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Isabelle Kelly | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Isabelle Robinson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 above | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Mem. Park 5/16/90 | | 20c. LOCATION — City or Town, State Landover, Md. | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gary H. Bratt | | | | 22. NAME AND ADDRESS OF FACILITY H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E. | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardio pulmonary failure. | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | |
| b. Terminal Stage of AIDS & multiple organ failure c. Due to (OR AS A CONSEQUENCE OF): d. | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Asim Ranjan Singh | | | | 29c. LICENSE NUMBER D39303 | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ASIM RANJAN SINGH, PGH 1 HOSPITAL DRIVE, Cheverly MD | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE Juha Davidson-Randall | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) TREGER REBECCA | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 13 1990 | | 3. TIME OF DEATH 12:21 PM | |
| 4. SOCIAL SECURITY NUMBER 212-12-5759 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03/26/11 | |
| 8. BIRTHPLACE (State or Foreign Country) NEW YORK | | | | 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MARYLAND | | | |
| 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 2706 JENNER DR., APT. C | |
| 10f. ZIP CODE 21209 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) HOUSEWIFE | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last) SOLOMON IURIE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) HANNAH COHEN | | | |
| 19a. INFORMANT'S NAME (Type/Print) DR. MICHAEL TREGER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1504 BROADWAY RD. LUTHERVILLE, MD 21093 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) HEBREW YOUNG MEN | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joel D Lewis</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & EROS, INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIOGENIC SHOCK | | | | | | | |
| Sequitently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| b. ACUTE MYOCARDIAL INFARCTION | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Swati Desai, HOUSE STAFF</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 05/13/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SWATI DESAI, SINAI HOSP. OF BALTIMORE, MD 21215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. |
|---|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM ROSENTHAL | | 2. DATE OF DEATH MONTH 5 DAY 13 YEAR 90 | | 3. TIME OF DEATH 12:10 A M |
| 4. SOCIAL SECURITY NUMBER 159-07-0775 | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 83 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 8-13-06 | 8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA |
| 9a. FACILITY NAME (If not institution, give street and number) LEVINDALE | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2500 W. BELVEDERE AVE., APT. 911 | | |
| 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII- | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) College | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PACKER & DELIVERY | | 16b. KIND OF BUSINESS/INDUSTRY RETAIL | | |
| 17. FATHER'S NAME (First, Middle, Last) KALMAN ROSETHAL | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MOLLIE UNKNOWN | | |
| 19a. INFORMANT'S NAME (Type/Print) MR. IRVING ROSENTHAL | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 POMONA NORTH, APT. 2 BALTIMORE, MD 21208 | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MT. SHARON | | 20c. LOCATION — City or Town, State SPRINGFIELD, PA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215 | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death 3 WEEK |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PROSTATE CANCER | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY — | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 28d. DESCRIBE HOW INJURY OCCURRED — | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER STAFF MD | | 29c. LICENSE NUMBER D20951 | | 29d. DATE SIGNED (Month, Day, Year) 5-13-90 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AT LUCIO, MD 2434 W BELVEDERE AVE Bldg 21215 5299 | | | | |
| 31. DATE SIGNED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE | | |

00 10343

90 13343

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Nelle Inez Roark | | | | 2. DATE OF DEATH May 12, 1990 | | 3. TIME OF DEATH 4:30pm | |
| 4. SOCIAL SECURITY NUMBER 234-42-7907 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 29 1926 | |
| 9a. FACILITY NAME (If not institution, give street and number) 2212 South thorn Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Middle River | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Middle River | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2212 South Thorn Road | | | | 10f. ZIP CODE 21220 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) | | 16b. KIND OF BUSINESS/INDUSTRY Essex Senior Center | | | |
| 17. FATHER'S NAME (First, Middle, Last) Arthur Gobel | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucy Simmons | | | |
| 19a. INFORMANT'S NAME (Type/Print) Glen Goetzinger | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 South Thorn Road Baltimore Maryland 21220 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Cemetery | | 20c. LOCATION — City or Town, State Baltimore Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Connelly Funeral Home</i> | | | | 22. NAME AND ADDRESS OF FACILITY ConnellyFuneralHome 300MaceAve. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Adenocarcinoma of the liver</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edolph M. Michael</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Franklin D. Pa. Balto Md. - 21237</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Jake Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13344

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY RYCHWALSKI | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-11-90 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 213-09-5026 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-4-18 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) 5603 DAYBREAK TERR. | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 5603 DAYBREAK TERR. | | 10f. ZIP CODE USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 YEARS | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH PITURA | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ? | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. MARY ANN MACIJEWSKI | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4714 SHAMROCK AVENUE BALTO. MD. 21206 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ST. STANISLAUS CEMETERY | | 20c. LOCATION — City or Town, State BALTO. MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles P. Kaczorowski</i> | | | | 22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTIMORE, MD. 21224 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>cerebral metastatic tumors</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>James S. Wolf</i> | | | | 29c. LICENSE NUMBER D27112 | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James S. Wolf, M.D., 9712 Belair Road, Balto., Md. 21236 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

271 82

Received of Mr. J. D. Smith

90 13345

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William Thornton Ross William ROSS | | | | 2. DATE OF DEATH MONTH DAY YEAR May 14 1990 | | 3. TIME OF DEATH 10:36 A M | |
| 4. SOCIAL SECURITY NUMBER 216-26-7359 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 52 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-28-38 | |
| 8. BIRTHPLACE (State or Foreign Country) Baltimore, Md. | | | | 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH Baltimore County | | | | 10. RESIDENCE OF DECEDENT | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6711 Apt. A-4 Havenoak Road | | | | 10f. ZIP CODE 21237 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1956-62 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12th Grade College (1-4 or 6+) College (1-4 or 6+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mailman | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Andrew Ross | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Thornton | | | |
| 19a. INFORMANT'S NAME (Type/Print) Marianne Ross | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 261 S. Ellwood Avenue Baltimore, Md.-21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cemetery | | 20c. LOCATION — City or Town, State Balto. Co. Md. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kathleen M. Murphy | |
| 22. NAME AND ADDRESS OF FACILITY 6415 Belair Road John C. Miller, Inc. Baltimore, Md.-21206 | | | | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Kidney Cancer (Hypernephroma) Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Marianne Ross | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIE STANBONE 120 Sister Anne Dr. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH MONTH DAY YEAR | | | | 3. TIME OF DEATH | | | | | |
|---|--|---|--|--|--|---|--|---|--|--|--|---|--|
| ROBERT RUSSELL | | | | 05 09 1990 | | | | 12:45 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 216-50-5580 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 42 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-18-48 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH BALTIMORE CITY | | | | | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 9910 Hoyt Circle | | | | 10f. ZIP CODE 21133 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) School | | | | 16b. KIND OF BUSINESS/INDUSTRY Dept. Head | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Milton Brooks Russell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Jackson Brooks | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Edwina J. Russell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9910 Hoyt Circle Randallstown, Md. 21133 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery | | | | 20c. LOCATION — City or Town, State | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dorothea Hector #281 | | | | 22. NAME AND ADDRESS OF FACILITY E.L. Phillips F.H. 1721-27 N. Monroe | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. CHRONIC MYELOGENOUS LEUKEMIA DUE TO (OR AS A CONSEQUENCE OF): c. POST ALLOGENIC BONE MARROW TRANSPLANT DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death 2 weeks 10 mos 77 days post BMT | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Laura Stevz MD | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/9/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LAURA STEVZ MD | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE Jehia Davidson-Randall | | | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT (First, Middle, Last) John I. Stromberg | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH 16:30 M | |
| 4. SOCIAL SECURITY NUMBER 217-01-1459 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2/4/09 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MD | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 6111 Moorefield Road | |
| 10f. ZIP CODE 21228 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) courier | | 16b. KIND OF BUSINESS/INDUSTRY civil service | |
| 17. FATHER'S NAME (First, Middle, Last) John W. Stromberg | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Schroen | | | |
| 19a. INFORMANT'S NAME (Type/Print) Cornelius Stromberg | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6111 Moorefield Rd/Balto. MD 21228 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cemetery | | 20c. LOCATION — City or Town, State Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Sterling Ashton Funeral Home, PA 736 Edmondson Ave/Balto. MD 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CHF a. DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Selma Inel, M.D.</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5-14-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Selma Inel JAH # 297 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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|---|--|--|--|--|---|--|--|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Madeleine Stevenson | | | 2. DATE OF DEATH MONTH 5 DAY 9 YEAR 90 | | 3. TIME OF DEATH 3:40 A.M. | | | | | | |
| 4. SOCIAL SECURITY NUMBER 578-07-2699 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-15-97 | | 8. BIRTHPLACE (State or Foreign Country) VA. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Presidential Woods Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Adelphi | | | 9c. COUNTY OF DEATH PG. | | | | |
| 10a. STATE D.C. | | | 10b. COUNTY N/A | | | 10c. CITY, TOWN OR LOCATION Washington | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 5230 North Capitol St., N.W. | | | | | 10f. ZIP CODE 20011 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4 or 5+) _____ | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Oliver Beal | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mittie Jones | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Margaret P. Woods | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 above | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Mem. Park 5/14/90 | | | 20c. LOCATION — City or Town, State Landover, Md. | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Larry H. Brett | | | | 22. NAME AND ADDRESS OF FACILITY H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E. | | | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiopulmonary Arrest Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Pneumonia c. Dense Senile Dementia. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER S. T. [Signature] | | | | | 29c. LICENSE NUMBER D 37934 | | 29d. DATE SIGNED (Month, Day, Year) 5/9/90 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. TRIFOGLIO, MD, 7500 Greenway Center Drive #430 Greenbelt MD. | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ROSA L. SHIELDS | | | | 2. DATE OF DEATH MONTH DAY YEAR 05/11/90 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 420-26-2437 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 01-18-25 | |
| 8. BIRTHPLACE (State or Foreign Country) ALA. | | 9a. FACILITY NAME (If not institution, give street and number) 1524 LESTER MORTON CT. | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, CITY | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1524 LESTER MORTON CT. | | | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th GRADE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC | | 16b. KIND OF BUSINESS/INDUSTRY P. FLANNIGAN & SON'S | | | |
| 17. FATHER'S NAME (First, Middle, Last) OTIS WYATT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ETHEL COLES | | | |
| 19a. INFORMANT'S NAME (Type/Print) MITCHELL SHIELDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1524 LESTER MORTON CT. BALTO, MD. 21205 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladys Wanner | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Bladder Cancer Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Mayer Gorbaty M.D. | | | | 29c. LICENSE NUMBER 027938 | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mayer Gorbaty 95 Aqueduct Rd. Glen Burnie, MD 21061 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) HOWARD SCOTT | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 9 1990 | | 3. TIME OF DEATH 5:40 P M | |
| 4. SOCIAL SECURITY NUMBER 241-24-4217 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) DEC 24 1924 | |
| 9a. FACILITY NAME (If not institution, give street and number) LEWINDALE HEBREW GERIATRIC HOSP | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1715 WEST NORTH AVENUE | | | |
| 10f. ZIP CODE 21217 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RETIRED | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLIE J. SCOTT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MELINDA STARK | | | |
| 19a. INFORMANT'S NAME (Type/Print) AVALON GREEN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1715 WEST NORTH AVENUE (21217) | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Shirlette K. Jones | | | | 22. NAME AND ADDRESS OF FACILITY Brown-Thompson F.H. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC SQUAMOUS CELL CARCINOMA, RIGHT TONGUE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Catharina O. Ku MA | | | | 29c. LICENSE NUMBER 5-15-90 017037 | | 29d. DATE SIGNED (Month, Day, Year) 5-10-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Esther Lita O. Ku MA, LEWINDALE HEBREW GERIATRIC HOSP | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Edward F. Schneider Sr. | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH 10:51 AM | |
| 4. SOCIAL SECURITY NUMBER 215-12-1680 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 5, 1922 | |
| 9a. FACILITY NAME (If not institution, give street and number) Loch Raven Veterans Administration Hosp. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH City | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Edgewood | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 602 Dogwood Road | | | | 10f. ZIP CODE 21040 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY Auto Service | | | |
| 17. FATHER'S NAME (First, Middle, Last) Adolph Schneider | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Moffat | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dolores Lee Schneider | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Dogwood Rd. Edgewood, Md. 21040 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood May 17, 1990 | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Gladden | | | | 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Inc. 5305 Harford Rd. 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Lung Cancer with Brain Metastasis DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Granulocytopenia DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| Approximate interval Between Onset and Death 1 week 5 months 1 week | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) N/A. | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ann Shirey Hagen MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann Shirey Hagen MD 22 South Greene Street Dept of Medicine Baltimore, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE J. Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Estelle A. Steiner | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-13-1990 | | 3. TIME OF DEATH 2:11a M | |
| 4. SOCIAL SECURITY NUMBER 4391 115-01-4391 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) AUG. 18, 1897 | |
| 9a. FACILITY NAME (If not institution, give street and number) BALTIMORE COUNTY GEN. HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH RANDALLSTOWN | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2905 FALLSTAFF RD., APT. 33 | | | | 10f. ZIP CODE #21209 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MANAGER | | 16b. KIND OF BUSINESS/INDUSTRY OFFICE | | | |
| 17. FATHER'S NAME (First, Middle, Last) EDWARD STEINER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) KATHERINE FRIEDLANDER | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. GILDA BAUM | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2025 W. ROGERS AVE. BALTO., MD 21209 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE HEBREW | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joel D. Levin | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSOWN RD. BALTO., MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiogenic Shock DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Allen J. Spivey M.D. | | | | 29c. LICENSE NUMBER 029085 | | 29d. DATE SIGNED (Month, Day, Year) 5-13-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Allen J. Spivey M.D. Balt. County General Hosp. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROSE SHERMAN | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 12 1990 | | | | 3. TIME OF DEATH 2:30 P M | |
| 4. SOCIAL SECURITY NUMBER 216-07-4242 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 10, 1900 | | 8. BIRTHPLACE (State or Foreign Country) RUSSIA | |
| 9a. FACILITY NAME (If not institution, give street and number) 6936 BLANCHE ROAD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO. | | | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6936 BLANCHE ROAD | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) GILBERT FRUMAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA UNKNOWN | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. NELSON (HELEN) HYMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3723 DOWNEY DALE DR. RANDALLSTOWN, MD 21133 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) LIBERTY PARK PROGRESSIVE BENEFIT | | 20c. LOCATION — City or Town, State RANDALLSTOWN | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON AND BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD. 21215 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular Disease Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Anterior sclerotic Disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D03078 | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. ELLI 5710 Old Court Rd. Randallstown, Md 21133 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROSE SCHWARTZ (ROSE SCHWARTZ) | | | | 2. DATE OF DEATH MONTH 5 DAY 17 YEAR 90 | | 3. TIME OF DEATH 2:32 PM | |
| 4. SOCIAL SECURITY NUMBER 212 30 9472 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) FEB. 28, 1910 | |
| 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4001 CLARKS LA., APT. 305 | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ADMINISTRATIVE | | 16b. KIND OF BUSINESS/INDUSTRY U.S. GOVERNMENT | | | |
| 17. FATHER'S NAME (First, Middle, Last) SAMUEL BOTWIN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA ROSENBERG | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. BARBARA GORDON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11819 PRESTWICK RD. POTOMAC, MD 20854 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE HEBREW | | 20c. LOCATION — City or Town, State REISTERSTOWN, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hypotension / Bradycardia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST G I bleeding PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure Hypothyroidism | | | | | | | Approximate interval Between Onset and Death |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Kenneth C. Russ, MD. | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kenneth C. Russ, MD c/o SINAI HOSPITAL BALTO MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2001 00

90 13355

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Mercedes SILVA | | | | 2. DATE OF DEATH MONTH DAY YEAR May 13 1990 | | 3. TIME OF DEATH 8:30 p M | |
| 4. SOCIAL SECURITY NUMBER 061-26-2725 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-25-28 | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4819 Bayonne Avenue | | | | 10f. ZIP CODE 21206 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: Puerto Rican | | 14. RACE — American Indian, Black, White, etc. Specify: Hispanic | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Book Binder | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Warren Otero | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Justa Rodriguez | | | |
| 19a. INFORMANT'S NAME (Type/Print) Felix Silva | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4819 Bayonne Avenue— Baltimore, MD. 21206 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kathleen M. Murphy | | | | 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road Baltimore, Md.—21206 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Edward M. Miller MD | | | | 29c. LICENSE NUMBER D19423 | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EDWARD M. MILLER, MD 5601 Loch Raven Blvd Baltimore 21235 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) NORMA M. SMOOT Norma M. Smoot | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 14 90 | | 3. TIME OF DEATH 11:35 A. M. | |
| 4. SOCIAL SECURITY NUMBER 21512 3820 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11/9/1920 | |
| 8. BIRTHPLACE (State or Foreign Country) Md. | | | | 9a. FACILITY NAME (If not institution, give street and number) MGRCY Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE MD | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3242 Kentucky Ave. | |
| 10f. ZIP CODE 21213 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 6+) Candy Packer | | | |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Wockenfuss Candy | | | | 17. FATHER'S NAME (First, Middle, Last) George McLain | | | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Shannhan | | | | 19a. INFORMANT'S NAME (Type/Print) Kenneth S. Smoot | | | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6038 Carter Ave. Balto., Md. 21214 | | | | 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | |
| 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cem. | | | | 20c. LOCATION — City or Town, State Balto., Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY John C. Miller Inc. 6415 Belair Rd. Balto., Md. 21206 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): Pneumonia | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): Valvular Heart disease | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | | |
| 28b. TIME OF INJURY M | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER R. Chan MD | | | | 29c. LICENSE NUMBER | | | |
| 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. Chan 301 St. Paul Place Baltimore, MD 21207 | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

22624 00

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Fern Tauber | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-8-90 | | 3. TIME OF DEATH 9:08AM | |
| 4. SOCIAL SECURITY NUMBER 212-26-5729A | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/23/27 | |
| 9a. FACILITY NAME (If not institution, give street and number) 4320 Clareway | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| 10a. STATE MD. | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION GLEN BURNIE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 310 HIGHLAND DR. APT. 201 | | | | 10f. ZIP CODE 21061 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James J. White</i> 5-15-90 | | | | 22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BOARD, BALTO., MD. 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Seizure disorder Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerotic cardiovascular disease Diabetes Mellitus | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO INSPECTION | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golle, Jr.</i> | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-8-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mario F. Golle, Jr., MD 111 Penn Street, Baltimore, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE <i>John D. ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) George S. Teass | | | | 2. DATE OF DEATH MONTH 05 DAY 12 YEAR 90 | | 3. TIME OF DEATH 12 PM | |
| 4. SOCIAL SECURITY NUMBER 006-01-3629 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03-06-09 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) St. Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland | |
| 9c. COUNTY OF DEATH Baltimore | | | | RESIDENCE OF DECEDENT | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore (TOWSON) | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 513 Locksley Rd. | | | | 10f. ZIP CODE 21204 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6 yrs | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman | | 16b. KIND OF BUSINESS/INDUSTRY Sales | |
| 17. FATHER'S NAME (First, Middle, Last) William H. Teass | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Georgie Walker | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorothy A. Teass | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Maria Cemetery 5/16/90 | | 20c. LOCATION — City or Town, State Towson, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc., 1050 York Rd. Towson, Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Obstructive Jaundice & Sepsis. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): Bilateral Pleural effusion. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Al Bassi MD | | | | 29c. LICENSE NUMBER D37250 | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ASHWANI K. BASSI ST. JOSEPH HOSPITAL BALTIMORE MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIE VENABLE (WILLIE LEE VENABLE) | | | | 2. DATE OF DEATH MONTH DAY YEAR 05-12-90 | | 3. TIME OF DEATH 11:45pm M | |
| 4. SOCIAL SECURITY NUMBER 215-07-9946 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 02-08-08 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1804 N. COLLINGTON AVE. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, CITY | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1804 N. COLLINGTON AVE | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th GRADE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.) College (1-4 or 5+) | | 16b. KIND OF BUSINESS/INDUSTRY BETHLEHEM STEEL | | | |
| 17. FATHER'S NAME (First, Middle, Last) FLOYD VENABLE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) NANNIE | | | |
| 19a. INFORMANT'S NAME (Type/Print) BLANCHE VENABLE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1804 N. COLLINGTON AVE. BALTO, MD. 21213 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Gladys Warner | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD WITH SUSPECTED MI DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER ▶ | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) ▶ | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13360

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Ernie Lee Washington | | | | 2. DATE OF DEATH MONTH 5 DAY 7 YEAR 90 | | 3. TIME OF DEATH 9:23PM M | |
| 4. SOCIAL SECURITY NUMBER 217-62-4815 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 36 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1/14/54 | |
| 9a. FACILITY NAME (If not institution, give street and number) Prince Georges General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cheverly | | 9c. COUNTY OF DEATH Prince Georges County | |
| 10a. STATE Md. | | 10b. COUNTY P.G. | | 10c. CITY, TOWN OR LOCATION Lanham | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5652 Whitfield Chapel Rd. | | | | 10f. ZIP CODE 20706 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chef | | 16b. KIND OF BUSINESS/INDUSTRY Restaurant | | | |
| 17. FATHER'S NAME (First, Middle, Last) Ernest Washington | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lualla Marsh | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lualla Washington | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 above | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Mem. Park 5/12/90 | | 20c. LOCATION — City or Town, State Landover, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Sally M. Pratt | | | | 22. NAME AND ADDRESS OF FACILITY H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple blunt force injuries to head and chest Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 5-7-90 | | 28b. TIME OF INJURY PM M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 28d. DESCRIBE HOW INJURY OCCURED Subject beaten | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) house | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Mario F. Golle, Jr., MD | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-8-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mario F. Golle, Jr., MD 111 Penn Street, Baltimore, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 13361

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Minnie Wilson | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH 7 19 PM | |
| 4. SOCIAL SECURITY NUMBER 220-20-5851 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03-12-27 | |
| 9a. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE MARYLAND | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2901 WEST LANVALE STREET | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMY FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BAKERY/LABORER | | 16b. KIND OF BUSINESS/INDUSTRY BAKERY | | | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLES E. WILSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY E. FRISBY | | | |
| 19a. INFORMANT'S NAME (Type/Print) JAMES TOLIVER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3941 COLCHESTE ROAD (21229) | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY | | 20c. LOCATION — City or Town, State LAUREL, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Rhonda K. Jones | | | | 22. NAME AND ADDRESS OF FACILITY BROWN/THOMPSON F.H. P.O. BOX 4433 (21223) | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio pulmonary arrest DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. HCCO, COPD, Angina DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER William B. B. Jones | | | | 29c. LICENSE NUMBER 027718 | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Willie W. Bings, M.D. 1200 Metro Plaza Bldg, Baltimore, Md 21215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

90 13362

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN EDWARD WOLFARTH | | | | 2. DATE OF DEATH MONTH 5 DAY 15 YEAR 90 | | 3. TIME OF DEATH 1200 P M | |
| 4. SOCIAL SECURITY NUMBER 215-12-9167 | | 5. SEX 1 M 2 F | 6. AGE (In yrs. last birthday) 68 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 3/19/22 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) ST AGNES HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 550 Parksley Avenue | | 10f. ZIP CODE 21223 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bartender | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Conrad Wolfarth | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hazel Davis | | | |
| 19a. INFORMANT'S NAME (Type/Print) Jerry E. Wolfarth | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 550 Parksley Ave. Baltimore, MD 21223 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park | | 20c. LOCATION — City or Town, State Elkridge, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Christopher H. Miles | | | | 22. NAME AND ADDRESS OF FACILITY Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Carcinoma of lung. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Lung Carcinoma. c. d. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D. Titanji, St Agnes Hospital Baltimore | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13363

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) OLIVE J. WILLIAMS | | | | 2. DATE OF DEATH MONTH 5 DAY 6 YEAR 90 | | 3. TIME OF DEATH 1935 | |
| 4. SOCIAL SECURITY NUMBER 244-40-4595 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/14/05 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) Baltimore County Gen. Hosp. | | 9b. CITY, TOWN, OR LOCATION OF DEATH Randallstown, Md | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN, OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 6+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Music Educator | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES H. WILLIAMS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CARRIE SCOTT | | | |
| 19. INFORMANT'S NAME (Type/Print) Beryl E.W. Williams | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4905 The Alameda | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Cemetery | | 20c. LOCATION — City or Town, State Baltimore Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Senia Adams Jones | | | | 22. NAME AND ADDRESS OF FACILITY Marshall W. Jones Jr. Funeral Home 1401 Edmondson Ave. Balto. Md 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASCVD, CHF Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DM, DEMENTIA, CVA | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER C. Ravi MD | | | | 29c. LICENSE NUMBER D37333 | | 29d. DATE SIGNED (Month, Day, Year) 5.6.90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. Ravi MD BCGH, RANDALLSTOWN, MD 21133 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Charles F. Wardley | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH 11:50 M | |
| 4. SOCIAL SECURITY NUMBER 213-03-1681 | | 5. SEX XX M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-4-07 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) FALLSTON GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH FALLSTON | |
| 9c. COUNTY OF DEATH HARFORD | | | | 10a. STATE Maryland | | 10b. COUNTY Harford | |
| 10c. CITY, TOWN OR LOCATION Abingdon | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 201 Miller Stone Court | |
| 10f. ZIP CODE 21009 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) College (1-4 or 5+) | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired - Foreman | | | | 16b. KIND OF BUSINESS/INDUSTRY Bathlehem Steel | | | |
| 17. FATHER'S NAME (First, Middle, Last) Benjamin James Wardley | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Alice Small | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Beverly Plummer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Miller Stone Court Abingdon, Md. 21009 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Inc. | | | |
| 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lassain Funeral Home Inc. | | | |
| 22. NAME AND ADDRESS OF FACILITY 7401 Belair Rd. Balto., Md. 21236 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. respiratory arrest DUE TO (OR AS A CONSEQUENCE OF): b. sepsis DUE TO (OR AS A CONSEQUENCE OF): c. multiple decubiti DUE TO (OR AS A CONSEQUENCE OF): d. multiple decubiti Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. nutrition deficits key contractures multiple decubiti | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER David S. Dunn | | | |
| 29c. LICENSE NUMBER D32279 | | | | 29d. DATE SIGNED (Month, Day, Year) 5/24/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID S. DUNN 1131 Belair Rd | | | | 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | |
| 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Julia A Waddles | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 1:10 A M | |
| 4. SOCIAL SECURITY NUMBER 510 46 5538 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 45 YRS. | | 7. DATE OF BIRTH MONTH 3 DAY 7 YEAR 45 | |
| 9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | 10b. COUNTY Prince Georges | | 10c. CITY, TOWN OR LOCATION Ft. Washington | | 10d. INSIDE CITY LIMITS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 12403 Parkton Ave. | | | | 10f. ZIP CODE 20744 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Army Reserves-ROTC | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | | 16b. KIND OF BUSINESS/INDUSTRY Elementary School | | | |
| 17. FATHER'S NAME (First, Middle, Last) Johnnie Chester Waddles, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lou Ann Tomlin | | | |
| 19a. INFORMANT'S NAME (Type/Print) George Waddles | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1448 W. 78th Street Chicago, IL. 60620 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Fairview Cemetery | | 20c. LOCATION — City or Town, State Vinita, OK. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes Arlington, Va. 22201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CHRONIC MYELOGENOUS LEUKEMIA IN BLAST CRISIS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death 6 mos | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Could not be determined | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) MD 20785 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEPHEN STAAL MD 8300 CORPORATE DR. CHANDLER | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13366

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Martin Weisman</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>12/16, 1990</i> | | 3. TIME OF DEATH <i>6:43 PM</i> | |
| 4. SOCIAL SECURITY NUMBER <i>163 01 4867</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>73</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>Sept. 2, 1916</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>Holy Cross Hosp</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i> | |
| 9c. COUNTY OF DEATH <i>Montgomery</i> | | | | 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Montgomery</i> | |
| 10c. CITY, TOWN OR LOCATION <i>Silver Spring</i> | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>1020 Loxford Terrace</i> | |
| 10f. ZIP CODE <i>20901</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WW II</i> | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>12 years</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Civil Service</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Department of the Army</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Joseph Weisman</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Clara Friedman</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Adella Errera Weisman</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1020 Loxford Terrace, Silver Spring, Maryland 20901</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>King David Memorial Garden</i> | | 20c. LOCATION — City or Town, State <i>Falls Church, Virginia</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald M. Stein</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial Dis</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>None</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John S. Rogers</i> | | | | 29c. LICENSE NUMBER <i>1907915</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>12/10/1990</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. John S. Rogers, M. D., 1919 Seminary Road, Silver Spring, Maryland 20910</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 16 1990</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN H WILLIAMS, Jr. | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH 01:33 A.M. | |
| 4. SOCIAL SECURITY NUMBER 215 07 1560 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-18-10 | |
| 9a. FACILITY NAME (If not institution, give street and number) 709 Lyndhurst Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 709 Lyndhurst Street | | | | 10f. ZIP CODE 21229 | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Navy | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired | | 16b. KIND OF BUSINESS/INDUSTRY Engineer | | | |
| 17. FATHER'S NAME (First, Middle, Last) John H. Williams Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lena | | | |
| 19a. INFORMANT'S NAME (Type/Print) Queen Williams | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Lyndhurst Street Balto., MD. 21229 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forrest Vet. | | 20c. LOCATION — City or Town, State Owings Mills, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Doretha Hector #281 | | | | 22. NAME AND ADDRESS OF FACILITY E.L. Phillips F.H. 1721-27 N. Monroe St. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. C Cardiopulmonary Arrest Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Gastric Carcinoma c. d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate Carcinoma Cholangitis | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER T. Williams MD | | | | 29c. LICENSE NUMBER Medical Resident | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3900 Loch Raven Blvd Baltimore 21218 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Reuben S. Young | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-9-90 | | 3. TIME OF DEATH 6:10 A M | |
| 4. SOCIAL SECURITY NUMBER 250-58-0528 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 50 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 1-18-40 | | 8. BIRTHPLACE (State or Foreign Country) S.C. | |
| 9a. FACILITY NAME (If not institution, give street and number) Baltimore County General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Md. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Balto. | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 501 W. Franklin St. | | | | 10f. ZIP CODE 21201 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unemployed | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Reuben Lee Young | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Pearson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Earl Young | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4014 Liberty Hgts. Ave., Balto., Md. 21215 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Auburn Cem. | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): b. Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Terminal lung CA & Brain Metastasis DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure Disorder, Dehydration | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D37949 | | 29d. DATE SIGNED (Month, Day, Year) 5-9-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Baltimore County General Hospital 5401 Old Court Rd. Randallstown Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

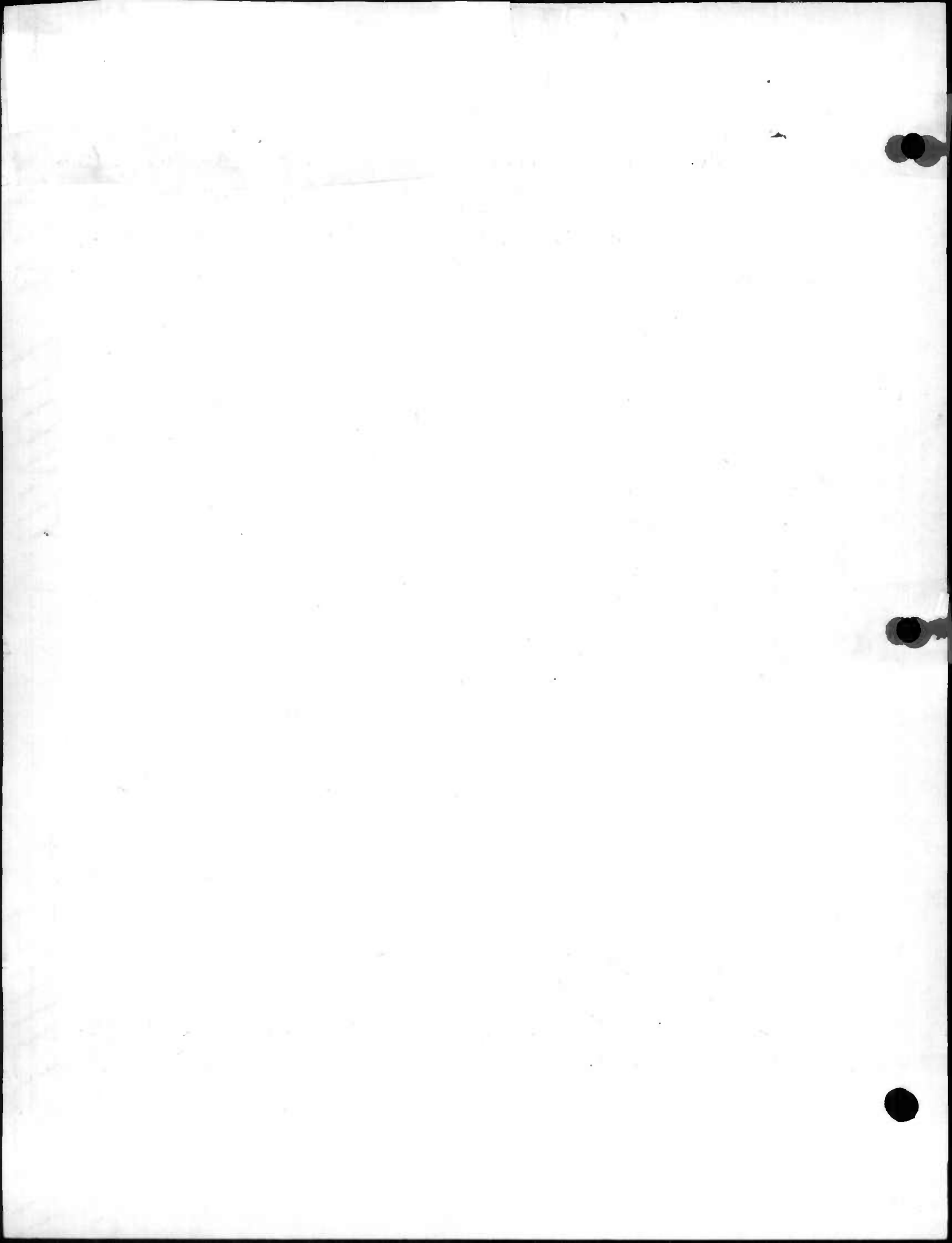
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

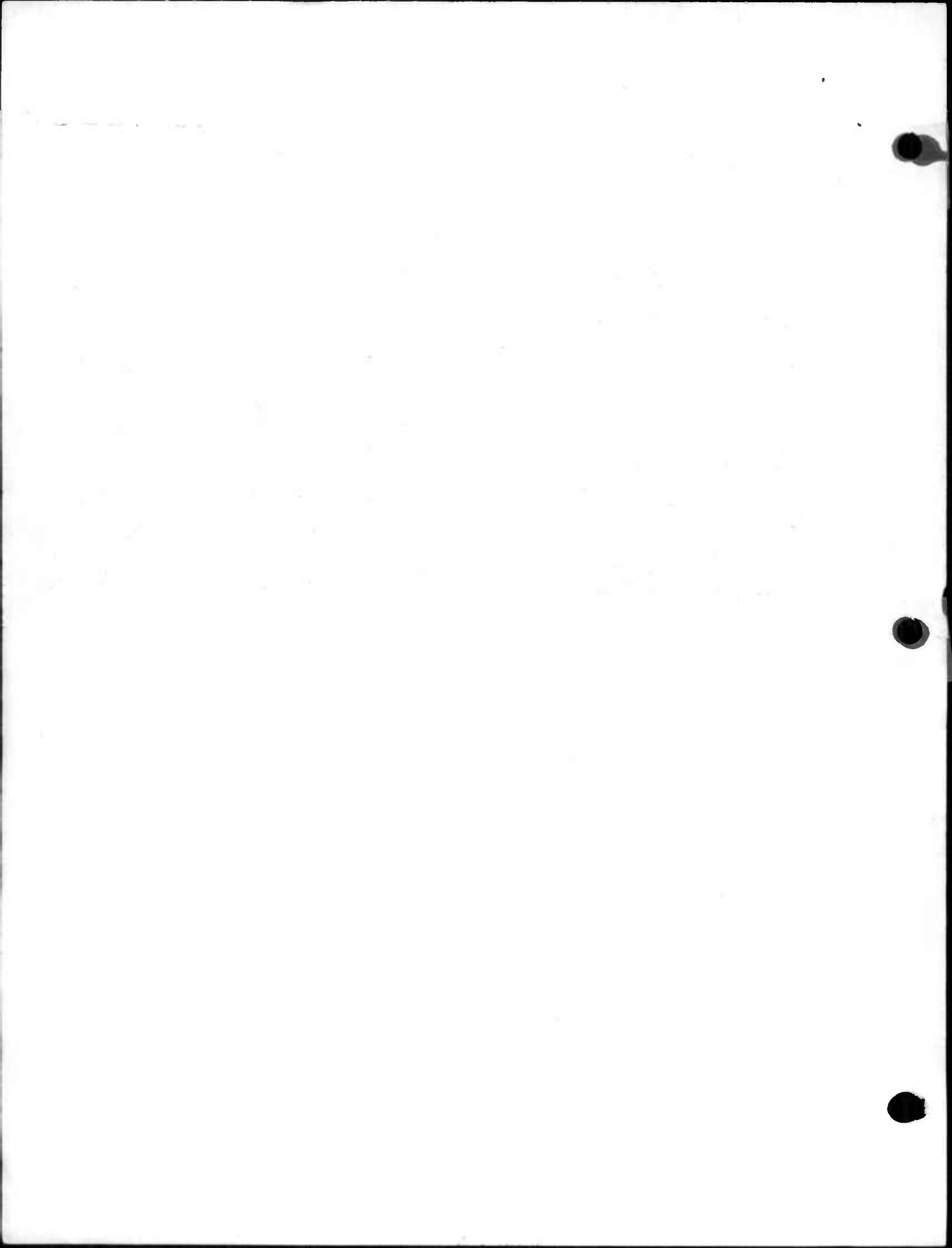
1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90-13369

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HILDA P. ANDERSON | | | | 2. DATE OF DEATH MONTH 5 DAY 16 YEAR 90 | | 3. TIME OF DEATH 1:52 P.M. | |
| 4. SOCIAL SECURITY NUMBER 213-16-3487 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3/14/03 | |
| 8. FACILITY NAME (If not institution, give street and number) MANOR CARE POSSVILLE | | | | 9. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, MD | | 10. COUNTY OF DEATH BALTIMORE | |
| 11. STATE MARYLAND | | 12. COUNTY Baltimore | | 13. CITY, TOWN OR LOCATION BALTIMORE | | 14. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 15. STREET AND NUMBER 6600 Ridge Rd. Baltimore, Md | | | | 16. ZIP CODE 21237 | | 17. CITIZEN OF WHAT COUNTRY? USA | |
| 18. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 21. RACE — American Indian, Black, White, etc. Specify White. | |
| 22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Book Binder | | 24. KIND OF BUSINESS/INDUSTRY Press Company | | | |
| 25. FATHER'S NAME (First, Middle, Last) Edward H. Copenhaver | | | | 26. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude E. Houck | | | |
| 27. INFORMANT'S NAME (Type/Print) Ferd J. Einschutz | | | | 28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8338 Roford Ave Balto, Md 21237. | | | |
| 29. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 30. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith | | 31. LOCATION — City or Town, State Balto Md. | | | |
| 32. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 33. NAME AND ADDRESS OF FACILITY 1211 Chesaca Ave Crach Rosedale FA Balto Md. | | | |
| 34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiovascular accident DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Abdominal aortic aneurysm Hypertension Depression | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 35. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 36. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 37. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 38. 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 39. 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | |
| 40. 28a. DATE OF INJURY (Month, Day, Year) 41. 28b. TIME OF INJURY 42. 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 43. 28d. DESCRIBE HOW INJURY OCCURRED 44. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 45. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 46. 29. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 47. 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 48. 29c. LICENSE NUMBER # 35593 | | 49. 29d. DATE SIGNED (Month, Day, Year) 5/16/90 | |
| 50. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN J. LOH, D.O., 617A STEMMERS RUN ROAD, BALTIMORE | | | | | | | |
| 51. 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 52. 32. REGISTRAR'S SIGNATURE | | | |



90 13370

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) NORA LEE BROWN | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 239-32-3006 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3 22 25 | |
| 9a. FACILITY NAME (If not institution, give street and number) 9620 Axehead Ct. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Md. | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Randallstown | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 2006 Payson Street | | | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY Day Care | | | |
| 17. FATHER'S NAME (First, Middle, Last) Ben Sauls | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nora Rose | | | |
| 19a. INFORMANT'S NAME (Type/Print) Annie Harper | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3602 Kings Point Rd., Balto., Md. 21133 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Mem. Pk. | | 20c. LOCATION — City or Town, State Arbutus, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Hala March | | | | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>metastatic Breast cancer</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Jeff Williamson M.D. | | | | 29c. LICENSE NUMBER D36557 | | 29d. DATE SIGNED (Month, Day, Year) May 14 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JEFF WILLIAMSON M.D. WATER MD. COR 861 PARK AVE 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Dorian A. Brown | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH 11:50PM M | |
| 4. SOCIAL SECURITY NUMBER 220-21-9043 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 7 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2/27/83 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MARYLAND | | | |
| 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1234 Seminole Avenue | | | |
| 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM G. BROWN, JR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) NORMA BROWN | | | |
| 19a. INFORMANT'S NAME (Type/Print) WILLIAM G. BROWN, JR. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1609 ST. STEPHANS ST.: BALTO. MD. 21216 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST CEMETERY | | 20c. LOCATION — City or Town, State OWINGS MILL, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i> | | | | 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Smoke and soot inhalation DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO INSPECTION |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 5-14-90 | | 28b. TIME OF INJURY 10:00P | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED Victim of house fire | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) home | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1234 Seminole Avenue, Baltimore County, Maryland | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frank Peretti</i> | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-15-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frank Peretti, MD 111 Penn Street, Baltimore, MD 21201 VC | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>J. Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARCUS J. BROWN | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 13, 1990 | | 3. TIME OF DEATH 5:08 P.M. | |
| 4. SOCIAL SECURITY NUMBER 058-56-4221 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 32 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10/19/57 | |
| 9a. FACILITY NAME (If not institution, give street and number) 2018 ASHLAND AVENUE (RESIDENCE) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2018 ASHLAND AVENUE | | | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) GRANVILLE P. BROWN, JR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BETTY M. PARRAN | | | |
| 19a. INFORMANT'S NAME (Type/Print) CLARETTA BROWN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2018 ASHLAND AVENUE: BALTO., MD. 21205 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i> | | | | 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ① Disseminated Mycobacterium Avium-Intracellular (MAI) infection DUE TO (OR AS A CONSEQUENCE OF): ② presumed central nervous system toxoplasmosis DUE TO (OR AS A CONSEQUENCE OF): ③ chronic weight loss DUE TO (OR AS A CONSEQUENCE OF): Acquired immunodeficiency syndrome DUE TO (OR AS A CONSEQUENCE OF): HIV infection | | | | | | | Approximate Interval Between Onset and Death 6 months |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) NA | | 28b. TIME OF INJURY NA M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED NA | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NA | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) NA | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER David W. Eldeh MD D.O. Fellow | | | | 29c. LICENSE NUMBER E9319 | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) (SAME AS 29b) DIV. OF INFECTIOUS DISEASE, Blalock 11, Johns Hopkins Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13373

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Dr. WILLARD L. BULGER | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH 11:30 P | |
| 4. SOCIAL SECURITY NUMBER 419-24-4959 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) 4/14/22 | | 8. BIRTHPLACE (State or Foreign Country) ALABAMA | | 9. FACILITY NAME (If not institution, give street and number) HOMEWOOD HOSPITAL CENTER | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE CITY | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3007 LaRUE SQUARE | | 10f. ZIP CODE 21239 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WORLDWAR II | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PHARMACIST | | 17. KIND OF BUSINESS/INDUSTRY RETIRED | | 18. FATHER'S NAME (First, Middle, Last) JAMES BULGER | |
| 19. MOTHER'S NAME (First, Middle, Maiden Surname) WILLIE MAE LANE | | 19a. INFORMANT'S NAME (Type/Print) DIANE BAUGH | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2041 WOODBOURNE AVE: BALTO., MD. 21239 | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i> | | 22. NAME AND ADDRESS OF FACILITY LEREOY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. METASTATIC CARCINOMA OF THE LUNG. b. HYPERCALCEMIA c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 5/14/90 | |
| 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ceballos, MD</i> | | 29c. LICENSE NUMBER D 25886 | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CEBALLOS, MD. - HOMEWOOD SOUTH HOSPITAL - BALTO. MD 21218 | | 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | 32. REGISTRAR'S SIGNATURE <i>John T. ...</i> | |

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ERNEST BLUMBERG | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 1235 M | |
| 4. SOCIAL SECURITY NUMBER 217-07-2901 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12/22/1897 | |
| 9a. FACILITY NAME (If not institution, give street and number) BALTO CO. GENERAL HOSP | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 8001 CATHERINE AVENUE | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWI | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 YRS College (1-4 or 5+) GUARD | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) GUARD | | 16b. KIND OF BUSINESS/INDUSTRY US GOVERNMENT | |
| 17. FATHER'S NAME (First, Middle, Last) LOUIS BLUMBERG | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARIAN HARTMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8001 CATHERINE AVE PASADENA, MD 21222 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTO NAT'L CEMETERY | | 20c. LOCATION — City or Town, State BALTO, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Elizabeth Howell | | | | 22. NAME AND ADDRESS OF FACILITY LILLY + ZEILER, INC FUNERAL HOME 700 S. CONKLING ST BALTO 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic Cardiovascular Disease | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> DUE TO (OR AS A CONSEQUENCE OF): Urthral Bleeding DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): </div> <div> Approximate Interval Between Onset and Death </div> </div> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NA | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Sue Oquendo House Physician | | | | 29c. LICENSE NUMBER D36456 | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sue Kiem Ong MD, Baltimore County General Hospital, Randallstown MD 21133 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician to the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOYCE Ann BROWN | | | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 10, 1990 | | | | 3. TIME OF DEATH 3:40 A.M. M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 216-36-5567 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs - last birthday) 48 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 3-31-42 | | 8. BIRTHPLACE (State or Foreign Country) New York | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH BALTIMORE CITY | | | | | | | |
| 10a. STATE Md | | | | | | 10b. COUNTY Baltimore | | | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | 10e. STREET AND NUMBER 526 N. Patterson Plk Ave | | | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Nathaniel Brown | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Brown | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Vanessa Ruffin | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5354 Sinclair Rd Balto, Md 21206 | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion | | | | 20c. LOCATION — City or Town, State Baltimore | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lewin Carroll | | | | | | 22. NAME AND ADDRESS OF FACILITY 1712-14 31. South Ave. | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. CARDIAC TAMPONADE + BLUNT TRAUMA SECONDARY TO MICHIGAN VENTILATOR 2 Days DUE TO (OR AS A CONSEQUENCE OF): b. ACUTE RESPIRATORY DISTRESS SYNDROME 5 Days DUE TO (OR AS A CONSEQUENCE OF): c. ASPIRATION 6 Days DUE TO (OR AS A CONSEQUENCE OF): d. ALCOHOL ABUSE 30 yrs | | | | | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEVERE DISORDER; HEPATIC FAILURE; CIRCULATORY FAILURE | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Phyllis A. MASTERS, MD | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Phyllis A. MASTERS, MD JOHNS HOPKINS HOSPITAL, BALTIMORE, MD 21205 | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | | | | | | | | | |


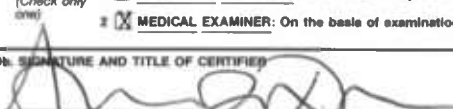

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ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HELEN BARNES | | | | 2. DATE OF DEATH MONTH 5 DAY 12 YEAR 90 | | 3. TIME OF DEATH 11:13 A M | |
| 4. SOCIAL SECURITY NUMBER 248-34-9408 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 64 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 10/6/25 | | 8. BIRTHPLACE (State or Foreign Country) S.C. | |
| 9a. FACILITY NAME (If not institution, give street and number) Bon Secours Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| 10a. STATE Md. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2031 W. Saratoga St. | | | | 10f. ZIP CODE 21223 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Horace Burns | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Camilla Wright | | | |
| 19a. INFORMANT'S NAME (Type/Print) Camilla Wright | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2031 W. Saratoga St. Baltimore Md. 21223 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Md. National Park | | 20c. LOCATION — City or Town, State Laurel, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21223 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Inspection |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-13-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann M. Dixon, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 vl | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1985

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | |
|---|--|---|--|--|--|---|--------------------------------|--|---|-------------------------------|--|
| John Thomas Brennan | | | | | | MONTH 5 DAY 11 YEAR 90 | | 0955 M | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | 6. AGE (In yrs. last birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | | |
| 119-01-1876 | | M F | 74 YRS. | | | | 9/9/15 | | Bloomfield, N.J. | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | 9c. COUNTY OF DEATH | | |
| North Arundel Hosp. | | | | | | Glen Burnie | | | AA | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | | | |
| Delaware | | Sussex | | Frankford | | | | 1 YES 2 NO | | | |
| 10e. STREET AND NUMBER | | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | | | |
| RD#2, Box 148 | | | | | 19945 | | USA | | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | | | 14. RACE — American Indian, Black, White, etc. | | | |
| 1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED | | 1 YES 2 NO WWII | | | 1 YES 2 NO Specify: | | | White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | |
| Elementary Secondary (0-12) College (1-4 or 5+) | | | | Electrician | | | Cyanamid Chemical Corp. | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | |
| Paul Brennan | | | | | | Jean McDermit | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| Kevin J. Brennan | | | | R.D. 2, Box 148, Frankford, Delaware 19945 | | | | | | | |
| 20a. METHOD OF DISPOSITION | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | | 20c. LOCATION — City or Town, State | | | | | |
| 1 BURIAL 2 CREMATION 3 REMOVAL FROM STATE 4 DONATION 5 OTHER (Specify) | | | Cape Henlopen Crematory | | | Frankford, Delaware | | | | | |
| 21. SIGNATURE OF FUNERAL HOME LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | |
| (Signature) | | | | Melson Funeral Services, Ltd. Frankford, Delaware 19945 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | Approximate Interval Between Onset and Death | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction | | | | | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST ASCVD | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 6 Residence 6 Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | | | M | | 1 YES 2 NO | | | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER William P. Jones, MD Deputy | | | | | | 29c. LICENSE NUMBER D06054 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | | | | | | | |
| William P. Jones, MD 695 America 21035 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE (Signature) | | | | | | | |

90 13378

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Rosario Cavallaro | | | | 2. DATE OF DEATH MONTH 5 DAY 15 YEAR 90 | | 3. TIME OF DEATH 10:20 A M | |
| 4. SOCIAL SECURITY NUMBER 209-01-9618 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3/2/1897 | |
| 8. BIRTHPLACE (State or Foreign Country) Italy | | | | 9a. FACILITY NAME (If not institution, give street and number) Mercy Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, MD | |
| 9c. COUNTY OF DEATH — | | | | 10a. STATE MD | | | |
| 10b. COUNTY — | | | | 10c. CITY, TOWN OR LOCATION Baltimore | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3419 Claremont Street | | | |
| 10f. ZIP CODE 21224 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (14 or 5+) — | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Shipyard Employee | | 16b. KIND OF BUSINESS/INDUSTRY Md. Drydock/Beth Steel | |
| 17. FATHER'S NAME (First, Middle, Last) ALFIO CAVALLARO | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MATILDA CAVALLARO | | | |
| 19a. INFORMANT'S NAME (Type/Print) ANTONETTA CAVALLARO | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3419 Claremont Street Balto Md 21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) OAKLAWN Cemetery Baltimore MD | | 20c. LOCATION — City or Town, State Baltimore MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph N. Zannino Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street Balto. Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Renal failure DUE TO (OR AS A CONSEQUENCE OF): b. Bladder cancer - metastatic DUE TO (OR AS A CONSEQUENCE OF): c. — DUE TO (OR AS A CONSEQUENCE OF): d. — Approximate Interval Between Onset and Death 1 year 1 year | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Chi M. Muthune MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jill M. Muthune MD 5460 Mount Hill Ct. Columbia, MD 21045 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE J. Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0767: 11

1. The first part of the report is a general
description of the project. It includes the
title, the objectives, the scope, and the
methodology. The second part is a detailed
description of the results. It includes the
data, the analysis, and the conclusions. The
third part is a discussion of the results.
It includes the interpretation of the results,
the limitations of the study, and the
recommendations for future research. The
fourth part is a conclusion. It includes the
summary of the findings and the final
recommendations.


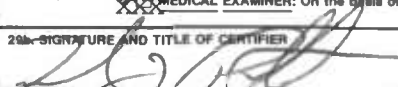

2148

ITEMS: 23, 27 per ME G-664
6-18-90 cm

90 13379

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Danielle (Danyell) Cook | | | 2. DATE OF DEATH MONTH DAY YEAR 5-7-90 | | 3. TIME OF DEATH 6:58AM M | |
| 4. SOCIAL SECURITY NUMBER none | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) YRS. 1 MONTHS 29 DAYS | 7. DATE OF BIRTH (Month, Day, Year) 3/8/90 | | 8. BIRTHPLACE (State or Foreign Country) Md. | |
| 9a. FACILITY NAME (If not institution, give street and number) 407 E. Chase Street | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE Md. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 407 E. Chase St. | | 10f. ZIP CODE 21201 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | |
| 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | |
| 17. FATHER'S NAME (First, Middle, Last) Ronnie Avery | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Cynthia Cook | | | |
| 19a. INFORMANT'S NAME (Type/Print) Cynthia Cook | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 E. Chase ST. Balto. Md. 21202 | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cem. | | 20c. LOCATION — City or Town, State Catonsville, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | 22. NAME AND ADDRESS OF FACILITY Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21217 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN INFANT SYNDROME DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 <input type="checkbox"/> NO | |
| | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 <input type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home XX Residence 8 <input type="checkbox"/> Other (Specify) | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XX <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-7-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frank Peretti, MD 111 Penn Street, Baltimore, MD 21201 vc | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | 32. REGISTRAR'S SIGNATURE  | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED'S NAME (First, Middle, Last) Robert P. Cahill | | | | | | 2. DATE OF DEATH MONTH 05 DAY 12 YEAR 90 | | 3. TIME OF DEATH 5:50 PM | |
| 4. SOCIAL SECURITY NUMBER 034-10-2929 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-23-18 | | 8. BIRTHPLACE (State or Foreign Country) Mass. | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE Md. | | 10b. COUNTY Howard | | 10c. CITY, TOWN OR LOCATION Columbia | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 11365 Little Patuxent Pkwy. Apt. 718 | | | | 10f. ZIP CODE 21044 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If YES, GIVE WAR OR DATES 1942-1963 Army | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired-Treasury Dept.-U.S. Government | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph M. Cahill | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise C. Lamoureux | | | |
| 19a. INFORMANT'S NAME (Type/Print) Thomas W. Cahill | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 Winans Way-Balto., Md. 21229 | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 5-16-90 | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE G. Truman Schwab | | | | 22. NAME AND ADDRESS OF FACILITY 5151 Balto. Nat'l Pike Baltimore, Md. 21229 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | |
| a. Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| b. Liver Metastasis DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| c. Liver Failure DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| d. | | | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ghassan Alayli, M.D. | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ghassan Alayli St. Agnes Hospital Balt Md 21229 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | 32. REGISTRAR'S SIGNATURE Ghassan Alayli | | | | | | | |

100-100000



90 13381

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CHINNIAH DORATSWAMY | | | | 2. DATE OF DEATH MONTH 5 DAY 12 YEAR 90 | | 3. TIME OF DEATH 10:51 M | |
| 4. SOCIAL SECURITY NUMBER 212-19-8354 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-15-09 | |
| 8. BIRTHPLACE (State or Foreign Country) India | | | | 9a. FACILITY NAME (If not institution, give street and number) 3755 Ceder La. | | 9b. CITY, TOWN OR LOCATION OF DEATH Columbia | |
| 9c. COUNTY OF DEATH Howard | | | | 10a. STATE Md. | | 10b. COUNTY Howard | |
| 10c. CITY, TOWN OR LOCATION Columbia | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 4600 Willow Grove Dr. | |
| 10f. ZIP CODE 21043 | | | | 10g. CITIZEN OF WHAT COUNTRY? India | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: Asian | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) MA College (1-4 or 5+) 5+ | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Inspector General of Government Employee | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Chinniah David | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Kalyaniammal | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sarojini G. Doraiswamy | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4600 Willow Grove Dr.-Ellicott City, Md. 21043 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. John's Cemetery | | | |
| 20c. LOCATION — City or Town, State Ellicott City, Md. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE G. Truman Schwab | | | |
| 22. NAME AND ADDRESS OF FACILITY 5151 Balto. Nat'l. Pike Baltimore, Md. 21229 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY ARREST DUE TO (OR AS A CONSEQUENCE OF): b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. BRONCHITIS DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Marilyn Vennery MD PHYSICIAN | | | |
| 29c. LICENSE NUMBER D35 791 | | | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARILYN VENNY MD 10305 GEORGIA AVE SILVER SPRING MD | | | | 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | |
| 32. REGISTRAR'S SIGNATURE G. Davidson | | | | 33. REGISTRAR'S OFFICE 20906 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Linda D. Douglas | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-13-90 | | 3. TIME OF DEATH 12:01PM M | |
| 4. SOCIAL SECURITY NUMBER 216-88-9216 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 20 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2 17 70 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1918 McCulloh Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| 10a. STATE Md. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Balto. | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1918 McCulloh Street | | | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Gregory M. Douglas, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel M. Bennett | | | |
| 19a. INFORMANT'S NAME (Type/Print) Gregory M. Douglas, Sr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1204 W. Fayette St., Balto., Md. 21223 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cem. | | 20c. LOCATION — City or Town, State Catonsville, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Portia Chron</i> | | | | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Gunshot wound of head</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 5-13-90 | | 28b. TIME OF INJURY AM M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) home | | 28e. DESCRIBE HOW INJURY OCCURRED Subject shot | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frank Peretti, MD</i> | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-14-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frank Peretti, MD 111 Penn Street, Baltimore, MD 21201 vc | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPHINE ANN DUPSKE | | | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 15 1990 | | 3. TIME OF DEATH 340 P M | |
| 4. SOCIAL SECURITY NUMBER 216-28-0233 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Mar. 17 1912 | | 8. BIRTHPLACE (State or Foreign Country) Hungary | |
| 9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSP 300 HOSPITAL DR | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE MD | | 9c. COUNTY OF DEATH ANNE ARUNDEL | |
| 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Glen Burnie | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7949 Crownsway | | | | 10f. ZIP CODE 21061 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) None | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress | | 16b. KIND OF BUSINESS/INDUSTRY Clothing | | | |
| 17. FATHER'S NAME (First, Middle, Last) George Miller | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva Miller | | | |
| 19a. INFORMANT'S NAME (Type/Print) Catherine Shaver | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemetery | | | | 20c. LOCATION — City or Town, State Brooklyn Park, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Amel B. Brown</i> | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD. 21061 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cy Brest cancer with metastases DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Davidson</i> | | | | | | 29c. LICENSE NUMBER D1P508 | | 29d. DATE SIGNED (Month, Day, Year) 5-15-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR CHARLES WU MD 7845 OAKWOOD ROAD GLEN BURNIE MD 21061 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) FLORENCE M. DONOVAN | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 15 1990 | | 3. TIME OF DEATH 7:20 P M | |
| 4. SOCIAL SECURITY NUMBER 220-30-7131 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 55 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12 25 1934 | |
| 8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD | | | | 9a. FACILITY NAME (If not institution, give street and number) G.B.M.C.-6701 N. CHARLES STREET | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | |
| 9c. COUNTY OF DEATH BALTIMORE COUNTY | | | | 10a. STATE MARYLAND | | | |
| 10b. COUNTY BALTIMORE CITY | | | | 10c. CITY, TOWN OR LOCATION 6111 FAIR OAKS AVE, BALTIMORE | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 6111 FAIR OAKS AVE | | | |
| 10f. ZIP CODE 21214 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Yrs. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM H. KAISER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie M. Bechtel | | | |
| 19a. INFORMANT'S NAME (Type/Print) Robert Donovan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6111 Fair Oaks Ave. Baltimore, Maryland 21214 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. 5/19/90 | | 20c. LOCATION — City or Town, State Cockeysville Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Milton J. Knight Jr | | | | 22. NAME AND ADDRESS OF FACILITY Leonard J Ruck, Inc. 5305 Harford Rd. 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → OVARIAN CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| b. Cardiopulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER 7-2066 | | 29d. DATE SIGNED (Month, Day, Year) 5-15-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Ruby I. Furl | | | | 2. DATE OF DEATH MONTH DAY YEAR May 15, 1990 | | 3. TIME OF DEATH 2 P.M. M | |
| 4. SOCIAL SECURITY NUMBER 214-01-7289 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-12-1907 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 4005 Hamilton Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 4005 Hamilton Ave. | |
| 10f. ZIP CODE 21206 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Yrs. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KING OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Julius Truitt | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Jarrett | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ella M. Jankowiak | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4005 Hamilton Ave., Balto., Md. 21206 | | | |
| 20. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olivet Cemetery 5-18-90 | | 20c. LOCATION — City or Town, State Balto., Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Roy H. Cather | | | | 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA, Cardiac arrest. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's disease | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Sheila Ebenezer, M.D. | | | | 29c. LICENSE NUMBER D29799 | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHEILA EBENEZER, M.D., 9512 Harford Rd Balto 21234 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE Julie Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-10-1964 212
C. J. J.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary S. Fowler | | | | 2. DATE OF DEATH MONTH 5 DAY 16 YEAR 90 | | 3. TIME OF DEATH 9:50 A M | |
| 4. SOCIAL SECURITY NUMBER 216-20-5589 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE 63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1/1/27 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MD | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 121 North Curley Street | |
| 10f. ZIP CODE 21224 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) unknown | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) housewife | | 16b. KIND OF BUSINESS/INDUSTRY own home | |
| 17. FATHER'S NAME (First, Middle, Last) Alexander Campoli | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Shirley McNish | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 North Curley Street/Balto. MD 21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore National | | 20c. LOCATION — City or Town, State Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Peter J. Ashten</i> | | | | 22. NAME AND ADDRESS OF FACILITY Moran-Ashten Funeral Home, Inc. 3000 E. Balto. St/Balto. MD 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiac Failure</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Shirley McNish</i> Med. resident | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/16/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Susan M. Friedman | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>J. A. Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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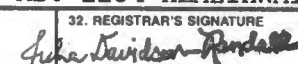


EMMA GRAVES

90 13388

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Emma Keith Graves | | 2. DATE OF DEATH MONTH 5 DAY 10 YEAR 90 | | 3. TIME OF DEATH 11: 30 P M | |
| 4. SOCIAL SECURITY NUMBER 047-32-1773 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) 12/15/1906 | | 8. BIRTHPLACE (State or Foreign Country) Vermont | | | |
| 9a. FACILITY NAME (If not institution, give street and number) SALISURY NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY, MD. | | 9c. COUNTY OF DEATH WICOMICO | |
| 10a. STATE Maryland | | 10b. COUNTY Wicomico C.onty | | 10c. CITY, TOWN OR LOCATION Salisbury | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER Salisbury Mobile Home Park Lot A-14 | | 10f. ZIP CODE 21801 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) housewife | | 16b. KIND OF BUSINESS/INDUSTRY b - - | |
| 17. FATHER'S NAME (First, Middle, Last) Parker Durrum | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophronia Baker | | | |
| 19a. INFORMANT'S NAME (Type/Print) Julie Graves Miller | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO box 314, Frankford, Delaware 19945 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Eastern Shore Crematorium | | 20c. LOCATION — City or Town, State Georgetown, Delaware | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | 22. NAME AND ADDRESS OF FACILITY Watson Funeral Home, Inc. Millsboro, Delaware 19966 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Sudden death</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <u>coronary artery disease</u> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER  | | 29c. LICENSE NUMBER D 29349 | |
| 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM ROBINS, MD. 1104 HEALTHWAY DRIVE, SALISBURY, MD. 21801 | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. The first part of the report
describes the general situation
of the country and the
main problems which
are facing it.

2. The second part of the report
describes the results of the
survey and the main
findings of the study.

3. The third part of the report
describes the conclusions
of the study and the
recommendations which
are being made.

[Signature]

Director - 1990

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last) Shirley J. House | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-13-90 | | 3. TIME OF DEATH 10:30PM M | |
| 4. SOCIAL SECURITY NUMBER 215-40-9177 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 48 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 09-19-41 | |
| 8. BIRTHPLACE (State or Foreign Country) N.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) 2844 E. Federal Street | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH | | | | | | | |
| 10a. STATE MD | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 2844 E. FEDERAL ST. | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th GRADE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MACHINE OPERATOR | | 16b. KIND OF BUSINESS/INDUSTRY J. MOLOFSKY SONS | | | |
| 17. FATHER'S NAME (First, Middle, Last) BEN COX | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) HATTIE NEWBORNE | | | |
| 19a. INFORMANT'S NAME (Type/Print) BERTHA LANGELEY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3042 E. FEDERAL ST. BALTO, MD. 21213 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladys Waned | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic cardiovascular disease and pneumonia | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-14-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frank Peretti, MD 111 Penn Street, Baltimore, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|--------------------------|--|--|---|--|---|--|-------------------------------------|--------------------------|-------|-------------------------------------|----------------|----------------------|-------------------------------------|--|--------|-------------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LILLE C. HAMLIN | | | | 2. DATE OF DEATH MONTH 5 DAY 12 YEAR 1990 | | 3. TIME OF DEATH M | | | | | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 220-12-1147 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3/22/1920 | | | | | | | | | | | | | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) HOME - 3055 SEAMON AVE, | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, MARYLAND | | | | | | | | | | | | | |
| 9c. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, MARYLAND 21225 | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | | | |
| 10e. STREET AND NUMBER 3055 SEAMON AVE, BALTIMORE, MARYLAND | | | | 10f. ZIP CODE 21225 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) GEORGE JOHNSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MILDRED JONES | | | | | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) GERALDINE CANN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3035 SEAMON AVE, BALTIMORE, MARYLAND 21225 | | | | | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY | | 20c. LOCATION — City or Town, State BROOKLYN, MARYLAND | | | | | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Carol A. Estep</i> | | | | 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL SERVICE, P.A. 1300 EUTAW PLACE, BALTIMORE, MD. 21217 | | | | | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ATHEROSCLEROTIC HEART DISEASE Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="0"> <tr> <td>a. DUE TO (OR AS A CONSEQUENCE OF):</td> <td>DIABETES MELLITUS</td> <td>2 YRS</td> </tr> <tr> <td>b. DUE TO (OR AS A CONSEQUENCE OF):</td> <td>CHRONIC</td> <td>RENAL FAILURE</td> </tr> <tr> <td>c. DUE TO (OR AS A CONSEQUENCE OF):</td> <td></td> <td>3 YRS.</td> </tr> <tr> <td>d. DUE TO (OR AS A CONSEQUENCE OF):</td> <td></td> <td></td> </tr> </table> | | | | | | | | a. DUE TO (OR AS A CONSEQUENCE OF): | DIABETES MELLITUS | 2 YRS | b. DUE TO (OR AS A CONSEQUENCE OF): | CHRONIC | RENAL FAILURE | c. DUE TO (OR AS A CONSEQUENCE OF): | | 3 YRS. | d. DUE TO (OR AS A CONSEQUENCE OF): | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | DIABETES MELLITUS | 2 YRS | | | | | | | | | | | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | CHRONIC | RENAL FAILURE | | | | | | | | | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | 3 YRS. | | | | | | | | | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALZHEIMER'S DISEASE | | | | | | | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | |
| 29. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | |
| 30. SIGNATURE AND TITLE OF CERTIFIER <i>John H. Harker</i> M.D. | | | | 31. LICENSE NUMBER D21716 | | 32. DATE SIGNED (Month, Day, Year) 3/14/90 | | | | | | | | | | | | | |
| 33. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3001 S HANOVER ST. BALTO. | | | | | | | | | | | | | | | | | | | |
| 34. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 35. REGISTRAR'S SIGNATURE <i>John Harker</i> | | | | | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Hall, Thomas Thomas L Hall | | | | 2. DATE OF DEATH MONTH 5 DAY 9 YEAR 90 | | 3. TIME OF DEATH 10:25 P M | |
| 4. SOCIAL SECURITY NUMBER 216 28 5030 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12/7/31 | |
| 9a. FACILITY NAME (If not institution, give street and number) Loch Raven VA Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore MD. | | 9c. COUNTY OF DEATH | |
| 10a. STATE Md. | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Severna Park | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 35 Hill Road | | | |
| 10f. ZIP CODE 21146 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 4/52 3/54 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner | | 16b. KIND OF BUSINESS/INDUSTRY T.L. Hall Trucking CO. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Leonard Hall | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Hall | | | |
| 19a. INFORMANT'S NAME (Type/Print) Delores Hall | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Hill Rd. Severna Park, Md. 21146 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Ch. Cemetery | | 20c. LOCATION — City or Town, State Magothy, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Paul A. Estep | | | | 22. NAME AND ADDRESS OF FACILITY Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate interval between Onset and Death 2 yrs. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia Hepatic Failure | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER John Portelli M.D. M0386 | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/9/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Loch Raven VA, Baltimore MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Rendell | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BYRON N. IVINS | | | | 2. DATE OF DEATH MONTH 05 DAY 12 YEAR 90 | | 3. TIME OF DEATH 6:10 A M | |
| 4. SOCIAL SECURITY NUMBER 213-05-9234 | | 5. SEX XX M 2 F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) NOV. 23, 07 | |
| 9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE | | 9c. COUNTY OF DEATH ANNE ARUNDEL | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION PASADENA | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 10e. STREET AND NUMBER 1818 DIVISION ROAD | | | | 10f. ZIP CODE 21122 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 Never Married 2 XX Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATHS | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) --- College (1-4 or 5+) --- | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SUPERINTENDENT | | 18b. KIND OF BUSINESS/INDUSTRY MAINTENANCE | | | |
| 17. FATHER'S NAME (First, Middle, Last) WALTER K. IVINS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BELLE (JACKSON) | | | |
| 19a. INFORMANT'S NAME (Type/Print) MR. BRYON G. IVINS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9621 HEATHCLIFF DR., BALTIMORE, MD 21237 | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Shane Savage | | 22. NAME AND ADDRESS OF FACILITY MC CULLY FUNERAL HOME OF PASADENA 3204 MOUNTAIN RD. PASADENA, MD 21122 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → GASTRIC BLEEDING DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST HIP FRACTURE, HEPATITIS | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Stephen D Brown M.D. | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEPHEN D BROWN, M.D. 200 HOSPITAL DR. #409 GLEN BURNIE, MD. 21061 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE Jane Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12/1/71

90 13393

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) KING DAVID JOHNSON | | | | 2. DATE OF DEATH MONTH 5 DAY 13 YEAR 90 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 218-18-9518 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 76 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 11-22-13 | | 8. BIRTHPLACE (State or Foreign Country) S.C. | |
| 9a. FACILITY NAME (If not institution, give street and number) MD. GENERAL HOSP. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| 10a. STATE MD | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, CITY | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2526 25th STREET | | 10f. ZIP CODE 21208 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 7th GRADE | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY BETHLEHEM STEEL | | 17. FATHER'S NAME (First, Middle, Last) BEGGIE JOHNSON | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA | | | | 19a. INFORMANT'S NAME (Type/Print) FANNIE M. BRANDON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4017 RIDGEWOOD AVE. BALTO, MD 21215 | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY | | 20c. LOCATION — City or Town, State CATONSVILLE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gladys Warren | | | | 22. NAME AND ADDRESS OF FACILITY March F. H. East 1101 E. North Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE MYOCARDIAL INFARCTION Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DIABETES MELLITUS | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | |
| 29c. LICENSE NUMBER 24089 | | | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. OSEI - WUSU MD 5710 WAABASH AVE. BALT. MD 21215 | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Maria Jarenko | | 2. DATE OF DEATH MONTH 5 DAY 10 YEAR 90 | | 3. TIME OF DEATH 3:45 P.M. | |
| 4. SOCIAL SECURITY NUMBER 19-321032 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 84 YRS. | |
| 9a. FACILITY NAME (If not institution, give street and number) Church Hospital Corporation | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| 10a. STATE Md. | | 10b. COUNTY XM | | 10c. CITY, TOWN OR LOCATION Baltimore City | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2001 E. Pratt St. | | 10f. ZIP CODE 21231 | |
| 10g. CITIZEN OF WHAT COUNTRY? | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 yrs. College (1-4 or 5+) CHARWOMEN | |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | 17. FATHER'S NAME (First, Middle, Last) GEORGE JAREMKO | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA ILLCHYSIN | | 19a. INFORMANT'S NAME (Type/Print) MYKOLA JAREMKO | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 E. PRATT ST. BALTO., MD. 21231 | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ST. MICHAEL'S UKR. CEM. | | 20c. LOCATION — City or Town, State BALTO., MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Andrew L. Howell | | 22. NAME AND ADDRESS OF FACILITY 21231 LILLY & ZEILER INC 1901 EASTERN AVE | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → STROKE DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER A. P. Nazemi, M.D. | | 29c. LICENSE NUMBER D17322 | |
| 29d. DATE SIGNED (Month, Day, Year) 5/10/90 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ataollah Nazemi Church Hospital 100 Broadway | | 31. DATE FILED (Month, Day, Year) MAY 17 1990 | |
| 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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90 13395

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HUNTER SPEECE LOWRY | | | | 2. DATE OF DEATH MONTH DAY YEAR May 15 1990 | | 3. TIME OF DEATH 12:51 P M | |
| 4. SOCIAL SECURITY NUMBER 171-10-1855 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 12, 1910 | |
| 8. BIRTHPLACE (State or Foreign Country) West Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH BALTIMORE CITY | | | | 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION Linthicum Heights | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 6217 Orchard Road | |
| 10f. ZIP CODE 21090 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Merchandise Manager | |
| 16b. KIND OF BUSINESS/INDUSTRY Montgomery Ward | | 17. FATHER'S NAME (First, Middle, Last) Edgar Lowry | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva C. Speece | | 19a. INFORMANT'S NAME (Type/Print) Eva K. Lowry | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6217 Orchard Road Linthicum Heights MD. 21090 | | 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery | | 20c. LOCATION — City or Town, State Baltimore, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Daniel B. Vinson | | 22. NAME AND ADDRESS OF FACILITY Singleton Funeral Home 1 Second Ave. S.W. Glen Burnie, MD. 21061 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory / Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Massive Cerebral Infarction DUE TO (OR AS A CONSEQUENCE OF): c. Emboli during cardiopulmonary bypass DUE TO (OR AS A CONSEQUENCE OF): d. Coronary Artery bypass Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | Approximate interval Between Onset and Death Immediate 8 days minutes | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. X | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 6 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER A. Clemens MD | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. Clemens MD | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | 32. REGISTRAR'S SIGNATURE Julia Davis | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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90 13396

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MABEL E. LYONS | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 15, 1990 | | 3. TIME OF DEATH 12:30 P M | |
| 4. SOCIAL SECURITY NUMBER 058-10-9810 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) OCT. 27, 10 | |
| 8. BIRTHPLACE (State or Foreign Country) NEW YORK | | | | 9a. FACILITY NAME (If not Institution, give street and number) NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE, MARYLAND | |
| 9c. COUNTY OF DEATH ANNE ARUNDEL | | | | 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | |
| 10c. CITY, TOWN OR LOCATION PASADENA | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 408 STATELY DRIVE | |
| 10f. ZIP CODE 21122 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th GRADE College (1-4 or 5+) NONE | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | | | 16b. KIND OF BUSINESS/INDUSTRY DOMESTIC | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES O'MALLEY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MABEL (BENSON) | | | |
| 19a. INFORMANT'S NAME (Type/Print) MR. BRUCE BAUER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10 a-f | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY, INC. CATONSVILLE, MD | | | |
| 20c. LOCATION — City or Town, State | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shane Savage</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY MC CULLY FUNERAL HOME OF PASADENA 3204 MOUNTAIN RD., PASADENA, MD 21122 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BILATERAL STROKE OF BRAINSTEM IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Bilateral stroke of brainstem</i> DUE TO (OR AS A CONSEQUENCE OF): HYPERTENSION b. <i>hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute dementia</i> | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>James J. Benjamin</i> | | | |
| 29c. LICENSE NUMBER D8387 | | | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAMES J. BENJAMIN, M.D., 653 OLD MILL ROAD, MILLERSVILLE, MARYLAND 21108 | | | | | | | |
| 31. DATE OF DEATH (Month, Day, Year) MAY 15 1990 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARK MIDDLEBROOKS | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 15 90 | | 3. TIME OF DEATH 6:45 PM | |
| 4. SOCIAL SECURITY NUMBER 260-30-7051 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12 18 26 | |
| 9a. FACILITY NAME (If not institution, give street and number) Liberty Med. Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| 10a. STATE Md. | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2908 Garrison Blvd. Apt. 5 T | | 10f. ZIP CODE 21216 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: X | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | 17. FATHER'S NAME (First, Middle, Last) Eugene Middlebrooks | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Julia | | | | 19a. INFORMANT'S NAME (Type/Print) Ernestine Middlebrooks | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2908 Garrison Blvd. Apt. 5-T 21216 | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest V.A. | | 20c. LOCATION — City or Town, State Owings Mill | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Portia Ebron | | | | 22. NAME AND ADDRESS OF FACILITY Wm. C. March Funeral Home 4300 Wabash Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Brain tumor. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Khaled Elkabi |
| 29c. LICENSE NUMBER D57806 | | | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Khaled Elkabi Liberty Medical Center | | | | | | | |
| 31. DATE OF DEATH (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Clarence Vincent McCabe | | | | 2. DATE OF DEATH MONTH DAY YEAR May 11 90 | | 3. TIME OF DEATH 0544 M | |
| 4. SOCIAL SECURITY NUMBER 221-26-2531 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 54 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 23 35 11 | |
| 8. BIRTHPLACE (State or Foreign Country) Delaware | | | | 9a. FACILITY NAME (If not institution, give street and number) Peninsula General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Salisbury, MD | |
| 9c. COUNTY OF DEATH Wicomico | | | | 10. RESIDENCE OF DECEDENT | | | |
| 10a. STATE delaware | | 10b. COUNTY Sussex | | 10c. CITY, TOWN OR LOCATION Millsboro | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER Rt. 3 Box 193 | | | | 10f. ZIP CODE 19966 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1951 - 1955 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) corporate dir- quality control | | 17. KIND OF BUSINESS/INDUSTRY poultry industry | | | |
| 17. FATHER'S NAME (First, Middle, Last) Clarence H. McCabe | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Hudson McCabe | | | |
| 19a. INFORMANT'S NAME (Type/Print) sue E. McCabe | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 3 Box 193, Millsboro, Delaware 19966 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Millsboro Cemetery | | 20c. LOCATION — City or Town, State Millsboro, Delaware | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard T. Watson | | | | 22. NAME AND ADDRESS OF FACILITY Watson Funeral Home, Inc. Millsboro, Delaware 19966 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gastrointestinal Bleeding DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John T. Bulkeley Deputy Medical Examiner | | | | 29c. LICENSE NUMBER D03599 | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John T. Bulkeley, M.D. Salisbury, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | 32. REGISTRAR'S SIGNATURE John T. Bulkeley | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LEONARD F. NEWSOME | | | | 2. DATE OF DEATH MONTH 05 DAY 15 YEAR 90 | | 3. TIME OF DEATH 5:45 A M | |
| 4. SOCIAL SECURITY NUMBER 220 07 4657 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 2 1921 | |
| 9a. FACILITY NAME (If not institution, give street and number) ST JOSEPH Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Essex | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1637 French's Ave. | | | |
| 10f. ZIP CODE 21221 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary (0-12) 6 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Letter Carrier | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Postal Service | | | |
| 17. FATHER'S NAME (First, Middle, Last) Jasper J. Newsome | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dora West | | | |
| 19a. INFORMANT'S NAME (Type/Print) Anna B. Newsome. Wife | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1637 French's Ave. Balto., Md. 21221 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Memorial Gardens | | 20c. LOCATION — City or Town, State Baltimore Co., Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home PA 1407 Old Eastern Ave. Balto., Md. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Progressive Lung Carcinoma Respiratory distress Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Ashwani K. Bassi M.D. | | 29c. LICENSE NUMBER D37250 | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ASHWANI K. BASSI M.D. ST. JOSEPH HOSPITAL BALTO. Md. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|--|--|---|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Hyman Otlin</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>5 2 90</i> | | 3. TIME OF DEATH <i>5 20 A M</i> | | |
| 4. SOCIAL SECURITY NUMBER <i>577 54 5016</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>86</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>7 26 03</i> | | |
| 8a. FACILITY NAME (If not institution, give street and number) <i>Haley Cross Hospital</i> | | | | 8b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring MD</i> | | 8c. COUNTY OF DEATH <i>Montgomery</i> | | |
| 10a. STATE <i>MD</i> | | | | 10b. COUNTY <i>Prince George's</i> | | 10c. CITY, TOWN OR LOCATION <i>Hyattsville</i> | | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER <i>630 Sheridan St</i> | | | | |
| 10f. ZIP CODE <i>20783</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8 years</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Bookbinder</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Office U.S. Government Printing</i> | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Morris Otlin</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Yetta (unascertainable)</i> | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Sylvia Otlin</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>630 Sheridan Street, Hyattsville, Maryland 20783</i> | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Mount Lebanon Cemetery</i> | | 20c. LOCATION — City or Town, State <i>Adelphi, Maryland</i> | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald M. Stein</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.</i> | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Emphysema</i> | | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): <i>Emphysema</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark H. Sig</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>5/2/90</i> | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Mark H. Sig 9801 Georgia Ave Silver Spring MD</i> | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 16 1990</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Rendell</i> | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30 1025

90 13401

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MINNIE M. (SCHNEIDER) OSTOVITZ | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 10 1990 | | | | 3. TIME OF DEATH 8:35p. M | | | | | |
| 4. SOCIAL SECURITY NUMBER 215-01-7205 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) NOV. 5, 1915 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 377 DUTCHSHIP ROAD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH PASADENA | | | | 9c. COUNTY OF DEATH ANNE ARUNDEL | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION PASADENA | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 377 DUTCHSHIP ROAD | | | | 10f. ZIP CODE 21122 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) 10th grade NONE | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SUPERVISOR | | | | 16b. KIND OF BUSINESS/INDUSTRY PRETZEL FACTORY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLES H. SCHNEIDER | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE (WALL) | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) CONSTANCE CAPEL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10 a-f | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK | | | | 20c. LOCATION — City or Town, State GLEN BURNIE, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Shane Savage | | | | 22. NAME AND ADDRESS OF FACILITY MCCULLY FUNERAL HOME OF PASADENA 3204 MOUNTAIN RD., PASADENA, MD 21112 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PROBABLE CARDIAC ARRHYTHEMIA a. <u>probable cardiac arrhythmia</u> <u>minutes</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>sepsis</u> (SEPSIS) <u>days</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>terminal pancreatic cancer</u> | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Sunny D. Sharbek, M.D. | | | | | | 29c. LICENSE NUMBER D29767 | | 29d. DATE SIGNED (Month, Day, Year) 5-11-90 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jerry D. SHARBEEK 8418 Baltimore-Annapolis Pasadena, MD 21122 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10/11/08

5/21/90 J.A.

90 13402

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) RUBY PRICE | | | | 2. DATE OF DEATH MONTH 05 DAY 14 YEAR 90 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 220-20-1998 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 61 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 08-01-28 | |
| 8. BIRTHPLACE (State or Foreign Country) BALTO, MD. | | | | 9a. FACILITY NAME (If not institution, give street and number) 1535 N. WOLF STREET | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH | | | | 10. RESIDENCE OF DECEDENT | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, CITY | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1620 N. WASHINGTON ST. | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 11th GRADE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) ZACK STEVENSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MINNIE SMITH | | | |
| 19a. INFORMANT'S NAME (Type/Print) JAMES STEVENSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12135 BUTTWOOD LN. CHASE, MD. 21220 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK | | 20c. LOCATION — City or Town, State ARBUTUS, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin L. Williams</i> | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Renal Failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Chronic Anemia</i> <i>Myocardial Infarct</i> <i>Hypertension</i> | | | | | | | Approximate Interval Between Onset and Death <i>5 months</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Anemia</i> <i>Myocardial Infarct</i> <i>Hypertension</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>E. Chaudhri</i> | | | | 29c. LICENSE NUMBER E 9866 | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. CHAUDHRI, Johns Hopkins Hospital Baltimore, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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CONFIDENTIAL

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEASED'S NAME (First, Middle, Last) CHRISTYNA PROCENKO | | | | 2. DATE OF DEATH MONTH DAY YEAR 5/14/90 | | 3. TIME OF DEATH 8:45 P.M. | |
| 4. SOCIAL SECURITY NUMBER 214-74-9383 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10/15/02 | |
| 9a. FACILITY NAME (If not institution, give street and number) CHURCH HOSPITAL CORPORATION | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEASED | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 212 S. COLLINGTON AVE. | | | | 10f. ZIP CODE 21231 | | 10g. CITIZEN OF WHAT COUNTRY? Ukraine | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Yrs College (1-4 or 5+) 2 Yrs. | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anastacia | | | |
| 19a. INFORMANT'S NAME (Type/Print) Tamara Boyko | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 S. Collington Ave. Baltimore, MD 21231 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Andrews Cemetery | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Elizabeth A. Nowell</i> | | | | 22. NAME AND ADDRESS OF FACILITY Lilly & Zeiler, Inc. Funeral Homes 1901 Eastern Avenue Balto., MD 21231 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary heart disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>B. Nagpal</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. B. NAGPAL, M.D. CHURCH HOSPITAL | | | | | | | |
| 31. DATE SIGNED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Robert Price | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 12 90 | | 3. TIME OF DEATH 4:30 A.M. | |
| 4. SOCIAL SECURITY NUMBER 242 42 4102 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 61 YRS. | 7. DATE OF BIRTH (Month, Day, Year) April 28, 1929 | | 8. BIRTHPLACE (State or Foreign Country) North Carolina | |
| 9a. FACILITY NAME (If not institution, give street and number) 11217 Dewey Court | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Kensington, | | 9c. COUNTY OF DEATH Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Kensington | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 11217 Dewey Court | | | | 10f. ZIP CODE 20895 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | | 16b. KIND OF BUSINESS/INDUSTRY Public Schools System | | | |
| 17. FATHER'S NAME (First, Middle, Last) Luther Price | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Patty Summerlin | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lois Perry Price | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Rolesville Cemetery | | 20c. LOCATION — City or Town, State Rolesville, NC | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes Arlington, Va. 22201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hepatitis Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death 5 mo. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Kenneth Miller, MD | | | | 29c. LICENSE NUMBER 03386 | | 29d. DATE SIGNED (Month, Day, Year) 5/12/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kenneth Miller, MD 18111 Pine Philip Dr. Olney, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

20131 72

90 13406

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Marie A. Siegfarth | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-16-90 | | 3. TIME OF DEATH AM PM 4:25 | |
| 4. SOCIAL SECURITY NUMBER 212-07-6587 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2-18-1905 | |
| 9a. FACILITY NAME (If not institution, give street and number) Mercy Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Maryland | |
| 10a. STATE Md. | | 10b. COUNTY — | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3516 E. Fayette Street | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) — | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERK | | 16b. KIND OF BUSINESS/INDUSTRY Eastern Union Blinds | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles Siegfarth | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa Zentgraf | | | |
| 19a. INFORMANT'S NAME (Type/Print) Catherine Siegfarth | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3520 E. Fayette Street Baltimore Md. 21224 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Redeemer Cem. | | 20c. LOCATION — City or Town, State Balto Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph N. Zannino Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Joseph N. Zannino Jr. Funeral Home 263 South Conkling Street 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic breast cancer DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate interval Between Onset and Death 3 years | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John Wiley MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/16/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Wiley, Mercy Hospital, 301 St Paul Pl, Balt MD 21202 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is crucial for ensuring the integrity of the financial system and for providing a clear audit trail.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in entering data into the system, from initial data collection to final verification and posting.

3. The third part of the document addresses the issue of data security. It discusses the various measures that should be implemented to protect sensitive information from unauthorized access, loss, or destruction.

4. The fourth part of the document focuses on the training and development of staff. It highlights the need for ongoing education and skill-building to ensure that all personnel are capable of performing their duties effectively and efficiently.

5. The fifth part of the document concludes with a summary of the key points discussed and provides recommendations for future action. It stresses the importance of continuous improvement and the need to stay up-to-date with the latest developments in the field.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90-13407

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Elizabeth D. Stohlman | | | | 2. DATE OF DEATH MONTH 5 - DAY 1 - YEAR 1990 | | | | 3. TIME OF DEATH 9:30 p.m. | | | |
| 4. SOCIAL SECURITY NUMBER 577-84-3381 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 15, 1903 | | 8. BIRTHPLACE (State or Foreign Country) VIRGINIA | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA | | | | 9c. COUNTY OF DEATH MONTGOMERY | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY MONTGOMERY | | 10c. CITY, TOWN OR LOCATION CHEVY CHASE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 8907 MONTGOMERY AVENUE | | | | 10f. ZIP CODE 20815 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN DANIEL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EDNA BISHOP | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARTIN A. STOHLMAN, JR. (SON) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 FONTAINE STREET, ALEXANDRIA, VIRGINIA 22302 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MOUNT OLIVET CEMETERY | | 20c. LOCATION — City or Town, State WASHINGTON, D.C. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James E. Dooley | | | | 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of Ovary Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John Pauber | | | | 29c. LICENSE NUMBER 708546 | | 29d. DATE SIGNED (Month, Day, Year) 5-2-90 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Pauber 8218 Wisconsin Ave Bethesda Md. | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 03 '90 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Pendell | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT S. STOVER | | | | 2. DATE OF DEATH MONTH 5 DAY 10 YEAR 90 | | 3. TIME OF DEATH 0820 A.M. | |
| 4. SOCIAL SECURITY NUMBER 216-36078 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In years, last birthday) 48 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/10/41 | |
| 8. FACILITY NAME (If not institution, give street and number) Liberty Medical Center Baltimore | | | | 9. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 10. COUNTY OF DEATH MD. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Longshore man | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Robert Stover Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Fanny Bell Stover | | | |
| 19a. INFORMANT'S NAME (Type/Print) Shirley Stover | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 439 Manse Co Baltimore, Md. 21201 | | | | | |
| 20. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 21. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt Zion Cemetery Balto. Md. | | 22. LOCATION — City or Town, State | | | |
| 23. SIGNATURE OF FUNERAL SERVICE LICENSEE Erwin Carroll | | | | 24. NAME AND ADDRESS OF FACILITY 1712-14 St. North Ave | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → BROTHENIC BRONCHOPNEUMONIA WITH | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): PULMONARY EMBOLISM AND SPORES | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): Stroke | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Gregory S. Gordon MD | | | | 29c. LICENSE NUMBER 039269 | | 29d. DATE SIGNED (Month, Day, Year) 5-10-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gregory S. Gordon MD Liberty Medical Center | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be associated within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit record.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CARL R S-PELTZER Spletzer | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 16 1990 | | 3. TIME OF DEATH 9:38 A. M. | |
| 4. SOCIAL SECURITY NUMBER 360-24-3753 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 14 1932 | |
| 8. BIRTHPLACE (State or Foreign Country) Illinois | | | | 9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie | |
| 9c. COUNTY OF DEATH Anne Arundel | | | | 10a. STATE Pennsylvania | | 10b. COUNTY Lackawanna | |
| 10c. CITY, TOWN OR LOCATION Scranton | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 238 Reese Street | |
| 10f. ZIP CODE 18508 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 6 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clergy | | 16b. KIND OF BUSINESS/INDUSTRY Lutheran Church | |
| 17. FATHER'S NAME (First, Middle, Last) Alvin A. Spletzer | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Linda Lange | | | |
| 19a. INFORMANT'S NAME (Type/Print) Marilyn F. Spletzer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Evergreen Cemetery | | 20c. LOCATION — City or Town, State Dickson City, Pa. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE CORONARY INSUFFICIENCY DUE TO (OR AS A CONSEQUENCE OF): b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): d. OBESITY Approximate interval Between Onset and Death 5 MINUTES | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M.D. | | | | 29c. LICENSE NUMBER D33757 | | 29d. DATE SIGNED (Month, Day, Year) 5-16-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES A. SEAGER M.D. 108 ASKUNTON ROAD SVPR | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Alice Josephine Seibert | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 2:40P M | |
| 4. SOCIAL SECURITY NUMBER 232-80-4185 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 19, 1904 | |
| 8. BIRTHPLACE (State or Foreign Country) Jefferson Co. WV | | | | 9a. FACILITY NAME (If not institution, give street and number) Fahrney Keedy Home | | 9b. CITY, TOWN OR LOCATION OF DEATH Boonsboro | |
| 9c. COUNTY OF DEATH Washington | | | | 10a. STATE MD | | 10b. COUNTY Washington | |
| 10c. CITY, TOWN OR LOCATION Boonsboro | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER Fahrney-Keedy Memorial Home, Inc. | |
| 10f. ZIP CODE 21713-9001 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Home | |
| 17. FATHER'S NAME (First, Middle, Last) S. Edward Clipp | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Lewis | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Anne Clipp | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 Evesham Avenue, Baltimore, MD 21212 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Rosedale Cemetery | | 20c. LOCATION — City or Town, State Martinsburg, WV | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles M. Brown</i> | | | | 22. NAME AND ADDRESS OF FACILITY Brown Funeral Home, 327 W. King Street PO Box 821, Martinsburg, WV 25401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death 1 month | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCD, dehydration, Aspiration pneumonia | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Vasant Datta, MD</i> | | | | 29c. LICENSE NUMBER D18019 | | 29d. DATE SIGNED (Month, Day, Year) 5.14.90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VASANT DATTA, MD 334 MILL ST HAGERSTOWN, MD 21740 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Gulian Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

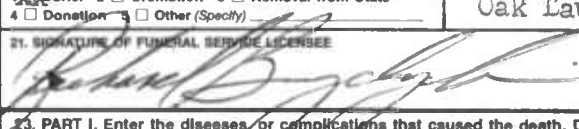

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Elaine Jackson AKA Lena Schultz | | | | 2. DATE OF DEATH MONTH DAY YEAR May 10, 1990 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 220 14 9479 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH MONTH DAY YEAR Dec. 17 1901 | |
| 9a. FACILITY NAME (If not institution, give street and number) 2 Mercy Court | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Middle River | | 9c. COUNTY OF DEATH Baltimore Co. | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Middle River | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2 Mercy Court | | | | 10f. ZIP CODE 21220 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) ? College (1-4 or 5+) ? | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesperson | | 16b. KIND OF BUSINESS/INDUSTRY Department Store | | | |
| 17. FATHER'S NAME (First, Middle, Last) Schultz | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Helen E. Tavik | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Jumpers Hole Rd. Severna Park, Md. 21146 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | 20c. LOCATION — City or Town, State Baltimore Co., Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home PA 1407 Old Eastern Ave. Balto., Md. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Breast Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death 6 mo |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 26d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER H. Ronald Friedman MD | | | | 29c. LICENSE NUMBER D01703 | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) H. Ronald Friedman MD 23 Crossroads Dr. Owens Mills, Md 21117 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 7, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

Dr. Rodgers
called - no
autopsy needed
90 13412

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Dolores S. Snyder | | | | 2. DATE OF DEATH MONTH 05 DAY 16 YEAR 90 | | 3. TIME OF DEATH 0308 AM | |
| 4. SOCIAL SECURITY NUMBER 219 16 8658 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2-15-20 | |
| 9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park | | 9c. COUNTY OF DEATH Montgomery Co. | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Essex | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 402 Essex Ave. Apt. C2 | | | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) George Lorber | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary A. 1 | | | |
| 19a. INFORMANT'S NAME (Type/Print) David Snyder | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1611 Waterbury Ct. Belair, Md. 21014 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Bruzdinski</i> | | | | 22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home PA 1407 Old Eastern Ave. Balto., Md. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC ARREST | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| b. HEART FAILURE, POOR LEFT VENTRI- | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. CULAR FUNCTION — PUMP FAILURE. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. PULMONARY HYPERTENSION | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CO.P.D. MITRAL STENOSIS DIABETES C.A.D. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Samir Nemat</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/16/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAMIR NEMAT MD. 7610 CARROLL Av. TAKOMA PARK, MD, 20912 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | 32. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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90 13413

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Harry Tate | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH 12:20 A M | |
| 4. SOCIAL SECURITY NUMBER 230-14-8727 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1/16/24 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington | | | | 9. FACILITY NAME (If not institution, give street and number) Francis Scott Key Hosp. | | 10. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 11. RESIDENCE OF DECEDENT | | | | 12. COUNTY md. | | 13. CITY, TOWN OR LOCATION Baltimore | |
| 14. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 15. STREET AND NUMBER 6400 Gary Ave. | | 16. ZIP CODE 21224 | |
| 17. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 18. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 21. RACE — American Indian, Black, White, etc. Specify: white | | 22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 yrs. College (1-4 or 5+) T.V. Repair | |
| 23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 24. KIND OF BUSINESS/INDUSTRY | | 25. FATHER'S NAME (First, Middle, Last) Newton Tate | |
| 26. MOTHER'S NAME (First, Middle, Maiden Surname) Ida | | | | 27. INFORMANT'S NAME (Type/Print) Tanya Rotundo | | 28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1311 Gusrayan St. Balto., Md. 21224 | |
| 29. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 30. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest V.A. Cem. | | 31. LOCATION — City or Town, State Garrison, Md. | |
| 32. SIGNATURE OF FUNERAL SERVICE LICENSEE Andrew L. Dault | | | | 33. NAME AND ADDRESS OF FACILITY Lilly & Zeiler Inc. 1901 Eastern Ave | | | |
| 34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alcoholism | | | | | | | |
| 35. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 36. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 37. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 38. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 39. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | | | 40. DATE OF INJURY (Month, Day, Year) | | | |
| 41. TIME OF INJURY M | | | | 42. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 43. DESCRIBE HOW INJURY OCCURRED | | | | 44. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 45. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 46. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 47. SIGNATURE AND TITLE OF CERTIFIER H.E. Fleming Jr. M.D. | | | | 48. LICENSE NUMBER E9913 | | 49. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 50. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) H.E. Fleming Jr. M.D. Francis Scott Key Hospital, Baltimore, MD | | | | | | | |
| 51. DATE FILED (Month, Day, Year) MAY 1 1990 | | | | 52. REGISTRAR'S SIGNATURE Davidson-Pendall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13414

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) MARGARET MARY TRUSLOW | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 15 1990 | | 3. TIME OF DEATH 2:00 P.M. | |
| 4. SOCIAL SECURITY NUMBER 156-18-1225 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 3, 1906 | |
| 8. BIRTHPLACE (State or Foreign Country) New York | | | | 9a. FACILITY NAME (If not institution, give street and number) 205 Homewood Road | | 9b. CITY, TOWN OR LOCATION OF DEATH Linthicum | |
| 9c. COUNTY OF DEATH Anne Arundel | | | | 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION Linthicum | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 205 Homewood Road | |
| 10f. ZIP CODE 21090 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) no | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Professional Musician | | 16b. KIND OF BUSINESS/INDUSTRY Self Employed | |
| 17. FATHER'S NAME (First, Middle, Last) James Rafferty | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Walsh | | | |
| 19a. INFORMANT'S NAME (Type/Print) Gloria M. Hólevés | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as # 10 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Beverly National Cemetery | | 20c. LOCATION — City or Town, State Beverly, N.J. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → VENTRICULAR ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): ATHERO SCLEROSIS DUE TO (OR AS A CONSEQUENCE OF): HIGH BLOOD PRESSURE AND CHRONIC RENAL FAILURE | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER D29296 | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gerard Lowder, 3001 S. Hanover St., Baltimore, Maryland 21230 | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | 32. REGISTRAR'S SIGNATURE | | | | | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

ALICE CO

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) John BABY BOY "A" (BRADLEY) THOMAS | | | | 2. DATE OF DEATH MONTH DAY YEAR 5/13/90 | | 3. TIME OF DEATH 7:42 P. M. | |
| 4. SOCIAL SECURITY NUMBER None | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 41 hrs. X06. | | 7. DATE OF BIRTH (Month, Day, Year) 5/12/90 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, Md. | | 9c. COUNTY OF DEATH Baltimore City | |
| 10a. STATE Md. | | 10b. COUNTY Balto. City | | 10c. CITY, TOWN OR LOCATION Baltimore, Md. | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4139 Hague Ave. | | 10f. ZIP CODE 21225 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) None | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) None | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Guy E. Thomas | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Angela Thomas Bruce | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Guy E. Thomas | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4139 Hague Ave. Balto. Md. 21225 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Mem. Park | | 20c. LOCATION — City or Town, State Elkridge, Howard Co. Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Samuel A. Taylor</i> | | | | 22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home. 130 E. Fort Ave | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Pulmonary Anectasis DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael E. Pelczar M.D.</i> | | | | 29c. LICENSE NUMBER D09990 | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael E. Pelczar, M.D. St. Agnes Hospital 900 Canon Ave. Balto Md. 21229 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01/11/20

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT W. THOMPSON | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 6:00 P M | |
| 4. SOCIAL SECURITY NUMBER 219-01-1359 | | 5. SEX XX M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) AUG. 20, 1920 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. CITY, TOWN OR LOCATION OF DEATH Glen Burnie | | 9c. COUNTY OF DEATH Anne Arundel | |
| 9b. FACILITY NAME (If not institution, give street and number) North Arundel Hospital | | | | 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | |
| 10c. CITY, TOWN OR LOCATION PASADENA | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 1701 SANDBAR LANE | |
| 10f. ZIP CODE 21122 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942 - 1945 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th grade College (14 or 5+) 4 + years | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LAWYER - ACCOUNTANT | | 16b. KIND OF BUSINESS/INDUSTRY SELF EMPLOYED | |
| 17. FATHER'S NAME (First, Middle, Last) SAMUEL W. THOMPSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH (WITZKE) | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. LAURA THOMPSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10 a-e | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK | | 20c. LOCATION — City or Town, State ELKRIDGE, HOWARD, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Shane Savage | | | | 22. NAME AND ADDRESS OF FACILITY McCULLY FUNERAL HOME OF PASADENA 3204 MOUNTAIN RD., PASADENA, MD 21122 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease complicated by pneumonia Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (Head Only) |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ann M. Dixon, M.D., Deputy Chief | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-13-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann M. Dixon, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 vl | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE John S. Anderson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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WATSON ANNA

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

90-13417

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Anna L. Watson | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 13 90 | | 3. TIME OF DEATH 11 37 A | |
| 4. SOCIAL SECURITY NUMBER 010-35-4287 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03 10 25 | |
| 9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital of Baltimore | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2503 Madison Ave | | | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Harry Owens | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) DENNIE Patterson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Charles Owens | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 Madison Ave, Balt., MD 21217 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cemetery | | 20c. LOCATION — City or Town, State Catonsville, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Portia Brown | | | | 22. NAME AND ADDRESS OF FACILITY March F. H. WEST 4300 Wabash Ave | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>a. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p> </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 5px;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Stephen O'Neil MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/13/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen O'Neil, Sinai Hospital of Baltimore | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 11 1990 | | 32. REGISTRAR'S SIGNATURE Jula Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1981 05

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Arthur F. Warren Sr. | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 10 80 | | 3. TIME OF DEATH 10 27 P M | |
| 4. SOCIAL SECURITY NUMBER 237-52-0857 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 54 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05-04-36 | |
| 8. BIRTHPLACE (State or Foreign Country) N.C. | | 9a. FACILITY NAME (If not institution, give street and number) FRANCIS SCOTT KEY | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| 10a. STATE MD | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, CITY | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2707 ASHLAND AVE. | | 10f. ZIP CODE 21205 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th GRADE College (1-4 or 5+) College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY HILL TRUCKING CO. | | 17. FATHER'S NAME (First, Middle, Last) FREEMAN WARREN | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) DALER JENKINS | | | | 19a. INFORMANT'S NAME (Type/Print) CAROLYN WARREN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2707 ASHLAND AVE. BALTO, MD. 21205 | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Blades Warren | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → HYPOTENSION | | | | | | | one day days |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. SEPSIS | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cirrhosis of the liver renal failure | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John J. Smith MD | | | | 29c. LICENSE NUMBER D32645 | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DUCAN MCCORMICK 4940 EASTERN AVE. BALTIMORE, MD 21224 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) SYLVESTER, WALKER | | | | 2. DATE OF DEATH MONTH 5 DAY 9 YEAR 90 | | 3. TIME OF DEATH 9:38 PM | |
| 4. SOCIAL SECURITY NUMBER 242-32-7315 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 63 | | 7. DATE OF BIRTH (Month, Day, Year) 8, 13, 26 | |
| 8. BIRTHPLACE (State or Foreign Country) NORTH CAROLINA | | | | 9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, MARYLAND | |
| 9c. COUNTY OF DEATH | | | | 10. RESIDENCE OF DECEDENT | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, MARYLAND | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2532 BOYD STREET, BALTIMORE, MARYLAND | | | | 10f. ZIP CODE 21223 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STEEL WORKER | | 16b. KIND OF BUSINESS/INDUSTRY SPARROW POINT | | | |
| 17. FATHER'S NAME (First, Middle, Last) REV. JAMES WALKER SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CALLIE POWELL | | | |
| 19a. INFORMANT'S NAME (Type/Print) JAMES T. WALKER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2719 LAURETTA AVE, BALTIMORE, MARYLAND 21223 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) WOODLAWN CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONFUSION, LETHARGY DUE TO (OR AS A CONSEQUENCE OF): b. BRAIN METASTASIS DUE TO (OR AS A CONSEQUENCE OF): c. OVAT CELL CA OF LUNG DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/9/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 37) (Type, Print) HABIB GHADDAR, 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|--|--|---|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Ashaki M. Umoja</u> AKA. CAROL SUE WILLIAMS | | | | 2. DATE OF DEATH MONTH <u>5</u> DAY <u>3</u> YEAR <u>90</u> | | 3. TIME OF DEATH <u>0950 AM</u> | | |
| 4. SOCIAL SECURITY NUMBER <u>214-54-4142</u> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (in yrs. last birthday) <u>40</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>11/2/49</u> | | 8. BIRTHPLACE (State or Foreign Country) <u>MARYLAND</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Union Memorial Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u> | | 9c. COUNTY OF DEATH | | |
| RESIDENCE OF DECEDENT | | | | | | | | |
| 10a. STATE <u>MARYLAND</u> | | 10b. COUNTY <u>BALTIMORE</u> | | 10c. CITY, TOWN OR LOCATION <u>BALTIMORE CITY</u> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER <u>1932 EAST 30th STREET</u> | | | | 10f. ZIP CODE <u>21218</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u> | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>HOUSE WIFE</u> | | 16b. KIND OF BUSINESS/INDUSTRY | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>THOMAS MERRICK SR.</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>SADIE MERRICK</u> | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>FAOULY A. UMOJA</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1932 E. 30th STREET BALTIMORE, MD. 21218</u> | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>METRO CREMATORY, INC</u> | | 20c. LOCATION — City or Town, State <u>BALTIMORE MD.</u> | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Carol A. Estep</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>ESTEP BROTHERS FUNERAL HOME</u> <u>1300 EUTAW PLACE BALTO, MD 21217</u> | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cerebral Anoxia</u> | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | |
| b. <u>Asthma Attack & respiratory Arrest</u> | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| c. <u></u> | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| d. <u></u> | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) <u>N/A</u> | | |
| 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Michael Hartman MD</u> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <u>5/3/90</u> | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>c/o Union Memorial Hospital Baltimore, MD</u> | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>5/3 MAY 17 1990</u> | | | | 32. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 13450

90 13421

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MOLLYE WILCOX | | | | 2. DATE OF DEATH MONTH 5 DAY 13 YEAR 90 | | 3. TIME OF DEATH 6:50 A M | |
| 4. SOCIAL SECURITY NUMBER 244 26 8043 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) February 5 1904 | |
| 8. BIRTHPLACE (State or Foreign Country) North Carolina | | | | 9a. FACILITY NAME (If not institution, give street and number) So-MARYLAND Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Chinton | |
| 9c. COUNTY OF DEATH P-G County | | | | 10a. STATE Maryland | | 10b. COUNTY Prince Georges | |
| 10c. CITY, TOWN OR LOCATION Beltsville | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 5021 Quimby Avenue | |
| 10f. ZIP CODE 20705 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Principal | | 16. KIND OF BUSINESS/INDUSTRY County schools | | | |
| 17. FATHER'S NAME (First, Middle, Last) Jacob Nathaniel Wilcox | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Winters | | | |
| 19a. INFORMANT'S NAME (Type/Print) Fern E. Terry | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5021 Quimby Avenue, Beltsville, Maryland 20705 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Elk Creek Park | | 20c. LOCATION — City or Town, State Elk Creek, N.C. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas W. Bachmayer | | | | 22. NAME AND ADDRESS OF FACILITY Arlington Funeral Home 3901 N. Fairfax Dr. Arlington, Virginia | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): Cardiomyopathy Compensative | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STOPPITOCOCOR SEPTIS CVA Previous POEMOKEN PERMANENT 5/11/90 | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 25. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 26. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 27. DATE OF INJURY (Month, Day, Year) | | 27b. TIME OF INJURY M | | 27c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27d. DESCRIBE HOW INJURY OCCURRED | | | | 28. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29a. SIGNATURE AND TITLE OF CERTIFIER W. E. Terry | | | | 29c. LICENSE NUMBER D24945 | | 29d. DATE SIGNED (Month, Day, Year) May 14, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7801 Old Branch Ave #409 Chinton, MD 20735 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13422

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JANE ZANNINO (Gigi) | | | | 2. DATE OF DEATH MONTH 5 DAY 16 YEAR 90 | | 3. TIME OF DEATH 0600 M | |
| 4. SOCIAL SECURITY NUMBER 216-74-1740 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 47 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 30, 1942 Md. | |
| 9a. FACILITY NAME (If not institution, give street and number) 7770 Gough Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, Md. | | 9c. COUNTY OF DEATH | |
| 10a. STATE Md. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7770 Gough Street | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) handicapped | | 15b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Larry Zannino | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Teresa Cosentino | | | |
| 19a. INFORMANT'S NAME (Type/Print) Teresa C. Zannino | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7770 Gough Street | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Entombment | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Oaklawn | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY Joseph N. Zannino, Jr. 263 S. Conkling Street, 21224 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate interval between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Exogenous obesity Diurnal Syndrome Trisomy | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER J.C. O'Donovan, M.D. | | 29c. LICENSE NUMBER DO 7632 | | 29d. DATE SIGNED (Month, Day, Year) 5-16-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J.C. O'Donovan 2112 Dundalk Ave., Balto., Md. 21222 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13423

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES ZIGLIER, Jr. | | | | 2. DATE OF DEATH MONTH 5 DAY 12 YEAR 90 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 238-40-3608 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3/4/33 | |
| 8. BIRTHPLACE (State or Foreign Country) Dunn, N.Car. | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 3908 Liberty Heights (Res.) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH Maryland | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore City | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3908 Liberty Heights Avenue | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 8+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Ziglier, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Corinia Ziglier | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lucille Ziglier | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3908 Liberty Heights Ave Balto., MD 21207 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cemetery | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i> | | | | 22. NAME AND ADDRESS OF FACILITY Leroy O. Dyett & Son Funeral Home 4600 Liberty Heights Avenue | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute MI DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER 010246 | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 23 Crossroads Drive, Owings Mills, Md. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 17 1990 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> 20777 | | | | | |

80 13453

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

90 13424

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Grace Nina Alford | | | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 - 14 - 90 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 213-12-3552 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4/10/20 | | 8. BIRTHPLACE (State or Foreign Country) PA. | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH Balto. City | |
| 10a. STATE MD. | | 10b. COUNTY Balto. City | | 10c. CITY, TOWN OR LOCATION Baltimore City | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3611 S. Hanover Street | | | | 10f. ZIP CODE 21225 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 11/19/43 - 11/7/45 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 9Th Grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Stock Clerk | | 16b. KIND OF BUSINESS/INDUSTRY Shermah & Williams | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) George B. Carter | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nina Grace Perkaiser | | | |
| 19a. INFORMANT'S NAME (Type/Print) Albert S. Alford | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3611 S. Hanover St. Balto., Md. 21225 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Crownsville Vet. Cem. | | 20c. LOCATION — City or Town, State Millersville, Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Hackman Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home 237 E. Patapsco Ave., Balto., Md. 21225 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Poisoned Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>a. DUE TO (OR AS A CONSEQUENCE OF): ASCD</p> <p>b. DUE TO (OR AS A CONSEQUENCE OF): COPD</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p> </div> <div style="width: 65%; border-left: 1px solid black; padding-left: 10px;"> <p>Approximate interval Between Onset and Death</p> </div> </div> | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Al Halliwell</i> | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3927, ANNAPOLIS ROAD 21227 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) SARA L. BETZ | | | | 2. DATE OF DEATH MONTH DAY YEAR 5/15/90 | | 3. TIME OF DEATH 3:00 A. M. | |
| 4. SOCIAL SECURITY NUMBER 217-22-1312 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6/12/05 | |
| 8a. FACILITY NAME (If not institution, give street and number) 800 Southerly Ave. | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 8c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10e. STREET AND NUMBER 800 Southerly Ave. | | 10f. ZIP CODE 21204 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | |
| 17. FATHER'S NAME (First, Middle, Last) Francis A. Lazenby | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sara C. Deming | | | |
| 19a. INFORMANT'S NAME (Type/Print) Josephine Merrill | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) James D. Stone 29 W. Susquehanna Ave 21204 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery | | 20c. LOCATION — City or Town, State Baltimore City | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William R. Davis III | | | | 22. NAME AND ADDRESS OF FACILITY Henry W. Jenkins Funeral Home 4905 York Rd. Balto. Md. 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. CARDIAC ARREST | | | | | | | 1 MM. |
| b. MYOCARDIAL INFARCTION | | | | | | | 1 MM. |
| c. CORONARY ARTERY DISEASE | | | | | | | 15 YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Donald L. Somerville, MD. | | | | 29c. LICENSE NUMBER D-12991 | | 29d. DATE SIGNED (Month, Day, Year) 5/16/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. DONALD L. SOMERVILLE, 500 VIRGINIA AVE, TOWSON, MD. 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Ida Bell Brown | | | | 2. DATE OF DEATH MONTH 05 DAY 17 YEAR 90 | | 3. TIME OF DEATH 7:30 AM | |
| 4. SOCIAL SECURITY NUMBER 219-20-8873 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 04-12-01 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland S.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) Mercy Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE Md. | | | |
| 10b. COUNTY E. | | | | 10c. CITY, TOWN OR LOCATION Baltimore | | | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1213 Light Street | | | |
| 10f. ZIP CODE 21230 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) UNEMPLOYED | | | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | |
| 16. KIND OF BUSINESS/INDUSTRY | | | | 17. FATHER'S NAME (First, Middle, Last) DANIEL BROWN | | | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) SALLIE BROWN BELL | | | | 19a. INFORMANT'S NAME (Type/Print) SALLIE MASON | | | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1025 BRANTLEY AVE. BALTO, MD. 21217 | | | | 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | |
| 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY | | | | 20c. LOCATION — City or Town, State CATONSVILLE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Julia R. March | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → cardiac arrhythmia | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): renal failure | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): hypertension | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): Staph endocarditis | | | | | | | |
| 24. SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Neuroth bowel | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER E. O. Deen | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 301 St. Paul Place, Baltimore, Maryland | | | | | | | |
| DATE FILED MAY 18 1990 DAY, MONTH, YEAR Julia R. March REGISTRAR'S SIGNATURE | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Deon Bose | | 2. DATE OF DEATH MONTH 5 - DAY 16 - YEAR 90 | | 3. TIME OF DEATH 7:13 PM | |
| 4. SOCIAL SECURITY NUMBER 579-94-4509 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 24 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) August 6, 1965 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Prince George's Community Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Cheverly | | 9c. COUNTY OF DEATH Prince George's | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Forestville | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1708 Forest Park Lane | | 10f. ZIP CODE 20747 | |
| 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3yrs. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Executive Secretary | | 16b. KIND OF BUSINESS/INDUSTRY Private | |
| 17. FATHER'S NAME (First, Middle, Last) John Richard Jordan | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruby Hall | | | |
| 19a. INFORMANT'S NAME (Type/Print) Charles Bose | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1708 Forest Park Lane, Forestville, Maryland 20747 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland National Mem. Park | | 20c. LOCATION — City or Town, State Laurel, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jimmy C. Neal Sr.</i> | | 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, Maryland 20785 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple injuries DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 5-12-90 | | 28b. TIME OF INJURY 945 PM | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED Pass./auto-fixed object impact | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) White House Rd, Lynn Mearns | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i> | | 29c. LICENSE NUMBER 021230 | |
| 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez MD 5009 Rayburn Ct Cp Spw MD 20748 | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transmittal form. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JACQUELINE BOSE | | | | 2. DATE OF DEATH MONTH 5 DAY 12 YEAR 90 | | 3. TIME OF DEATH 11:15 P M | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 8. AGE (In yrs. last birthday) 1 YRS. | IF UNDER 1 YEAR MONTHS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) June 4, 1988 | |
| 9a. FACILITY NAME (If not institution, give street and number) Prince George's General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cheverly | | 9c. COUNTY OF DEATH Prince George's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Forestville | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1708 Forest Park Dr. | | | | 10f. ZIP CODE 20747 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A | | College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A | | 16b. KIND OF BUSINESS/INDUSTRY N/A | |
| 17. FATHER'S NAME (First, Middle, Last) Charles Bose | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Deon Jordan | | | |
| 19a. INFORMANT'S NAME (Type/Print) Charles Bose | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1708 Forest Park Dr. Forestville, Maryland 20747 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland National Mem. Park | | 20c. LOCATION — City or Town, State Laurel, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, Maryland 20785 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Craniocerebral Trauma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 26a. DATE OF INJURY (Month, Day, Year) 5-12-90 | | 26b. TIME OF INJURY 9:45 P M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 26d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) roadway | | 26e. DESCRIBE HOW INJURY OCCURRED Passenger in auto/fixed object impact | | | |
| | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Ritchie Marlboro Rd., Upper Marlboro, P.G. Co. | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MD 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-13-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann M. Dixon, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 vl | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1020:11 CC

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

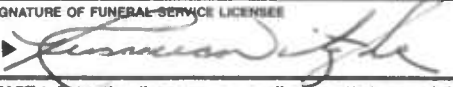
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| | | | | | | | | | |
|--|--|---|--|---|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Walter S. Broening, Sr. | | | | 2. DATE OF DEATH MONTH DAY YEAR May 16, 1990 | | 3. TIME OF DEATH 2:30 p.m. | | | |
| 4. SOCIAL SECURITY NUMBER 225-10-1503 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06-01-1905 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) 607 Somerset Road, Apt 1 21210 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | 9c. COUNTY OF DEATH ----- | | |
| 10a. STATE Maryland | | 10b. COUNTY ----- | | 10c. CITY, TOWN OR LOCATION Baltimore | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 607 Somerset Road Apt #1 | | | | 10f. ZIP CODE 21210 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (1-4 or 5+) 4yrs | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Manager | | | 16b. KIND OF BUSINESS/INDUSTRY Truck Sales | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Broening, Jr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Stephens | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Walter S. Broening, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4400 Roland Avenue, Balto., MD 21210 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc | | 20c. LOCATION — City or Town, State Baltimore, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb | | | | 22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland 299 Frederick Road, Balto., MD 21228 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>prostatic cancer</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death yrs | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Alan Kimmel | | | | 29c. LICENSE NUMBER D25783 | | 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Alan L. Kimmel, M. D., 220 W. Cold Spring Lane, Baltimore, MD 21210 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MILLARD W. BOWMAN | | | | 2. DATE OF DEATH MONTH 5 DAY 17 YEAR 1990 | | 3. TIME OF DEATH 1:00 A. M | |
| 4. SOCIAL SECURITY NUMBER 216-09-4361 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5/7/18 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | 9a. FACILITY NAME (If not institution, give street and number) 3 GINFORD PLACE # 201 | | 9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION CATONSVILLE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3 GINFORD PLACE # 201 | | 10f. ZIP CODE 21228 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SERVICE WORK | | 16b. KIND OF BUSINESS/INDUSTRY B. G. & E. COMPANY | | | |
| 17. FATHER'S NAME (First, Middle, Last) ALBERT BOWMAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY FLYNN | | | |
| 19a. INFORMANT'S NAME (Type/Print) ELEANOR BOWMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) # 201 3 GINFORD PLACE CATONSVILLE, MD. 21228 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) POPLAR SPRINGS METHODIST CEMETERY POPLAR SPRINGS, MD. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY 1630 EDMONDSON AVE. CATONSVILLE, MD. 21228 LEROY M. & RUSSELL C. WITZKE FUNERAL HOME | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Respiratory failure DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | b. Metastatic melanoma DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Thomas J. Sweet | | | | 29c. LICENSE NUMBER D 35853 | | 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 22 South Greene Street, Baltimore MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21/01/25



90 13431

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) James Borowy | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 16 99 | | 3. TIME OF DEATH 3:00 PM | |
| 4. SOCIAL SECURITY NUMBER 213104607 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-6-11 | |
| 8. BIRTHPLACE (State or Foreign Country) Mississippi | | | | 9a. FACILITY NAME (If not institution, give street and number) Church Hospital Corporation | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH | | | | 10. RESIDENCE OF DECEDENT | | | |
| 10a. STATE Md. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore City | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 216 S. WASHINGTON ST. | | | | 10f. ZIP CODE BAHD. 21231 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) BAHD. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Parts Clerk | | 16b. KIND OF BUSINESS/INDUSTRY GENERAL Motors | | | |
| 17. FATHER'S NAME (First, Middle, Last) ALEXANDER J. BOROWY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARYANN A. (UNKNOWN) | | | |
| 19a. INFORMANT'S NAME (Type/Print) JOANNA DAVIES | | | | 19b. MAILING ADDRESS (Street and Number, or Rural Route Number, City or Town, State, Zip Code) 627 N. Curly St. BAHD. MD. 21205 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Rosary Cemetery | | 20c. LOCATION — City or Town, State BAHD. MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edward Weber | | | | 22. NAME AND ADDRESS OF FACILITY EDWARD J. WEBER FH. 401 S. Thelster St. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Apnea due to gm (+) cocci, most likely staphylococcus aureus DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure with electrolyte Major depression Arteriosclerotic cardiovascular disease | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Chi-Shiang Chen MD |
| 29c. LICENSE NUMBER | | | | | | | 29d. DATE SIGNED (Month, Day, Year) 5-16-99 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Chi-Shiang Chen Church Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1999 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Henry Hunter Bussard | | | | 2. DATE OF DEATH MONTH 5 DAY 6 YEAR 90 | | | | 3. TIME OF DEATH 4:42 P.M. | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 229-24-2006 | | | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2/10/1924 | | 8. BIRTHPLACE (State or Foreign Country) West Virginia | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Clinton | | | | 9c. COUNTY OF DEATH Prince George's | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Prince George's | | | | 10c. CITY, TOWN OR LOCATION Brandywine | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 40 Canter Drive | | | | | | 10f. ZIP CODE 20613 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| Elementary/Secondary (0-12) -8- | | | | | | College (1-4 or 5 +) Heavy Equipment Operator | | | | Construction | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Marion Bussard | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Myrtle Davis | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sara Jewell | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as Item 10a-10f | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Bussard Family Cemetery | | | | 20c. LOCATION — City or Town, State Frost, West Virginia | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00690 Howard A. Carson | | | | | | 22. NAME AND ADDRESS OF FACILITY Van Reenen Funeral Home 207 9th Street, Marlinton, W VA 24954 | | | | | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of the Prostate and Esophagus Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> POA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Augusto P. Rodriguez | | | | | | 29c. LICENSE NUMBER D-31230 | | | | 29d. DATE SIGNED (Month, Day, Year) 5-6-90 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez, M.D. 5007 Rayburn Court, Camp Springs, Maryland | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson | | | | | | | | | | | |

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Isidore Brown | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 13 90 | | 3. TIME OF DEATH HOURS MIN. SEC. 12 30 A | |
| 4. SOCIAL SECURITY NUMBER 050-26-4211 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06-27-05 | |
| 8. BIRTHPLACE (State or Foreign Country) New York | | | | 9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hosp. | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Springs, MD. | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Mpntgomery | |
| 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 8103 Eastern Avenue, Apt. 409 B | |
| 10f. ZIP CODE 20910 | | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk | | 16b. KIND OF BUSINESS/INDUSTRY U. S. Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Mayer Brown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Leah Brook | | | |
| 19a. INFORMANT'S NAME (Type/Print) Barbara Brown | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8103 Eastern Avenue, Apt. 409B Silver Spring, Md. | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Floral Park | | 20c. LOCATION — City or Town, State Deans, New Jersey | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald M. Stein | | | | 22. NAME AND ADDRESS OF FACILITY DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute cerebral hemorrhage DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death 72 hrs | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerosis Cardiovascular Disease | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Myron L. Lenkin MD | | | | 29c. LICENSE NUMBER D06674 | | 29d. DATE SIGNED (Month, Day, Year) 5/13/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MYRON L. LENKIN 2309 SHOREFIELD RD WHEATON MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|-------------------------------------|---|---|--|--|
| 1. DECEASED'S NAME (First, Middle, Last) IRVIN CLYDE BECHTEL | | | | 2. DATE OF DEATH MONTH 05 DAY 13 YEAR 90 | | 3. TIME OF DEATH 1525 M | | | |
| 4. SOCIAL SECURITY NUMBER 215-30-6755 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-21-1932 | | 6. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA | |
| 9a. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | 9c. COUNTY OF DEATH | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION EDGEMERE | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 7237 RIVERDRIVE ROAD | | | | 10f. ZIP CODE 21219 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11TH GRADE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WELDER | | 16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) CLYDE I. BECHTEL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET A. McNOLDY | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) ELIZABETH L. BECHTEL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7237 RIVERDRIVE ROAD BALTIMORE, MARYLAND 21219 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH CEMETERY 5-17-90 BALTIMORE, MARYLAND | | | 20c. LOCATION — City or Town, State | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPTIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. CONGESTIVE HEART FAILURE b. RENAL FAILURE c. PERITONEAL DIALYSIS d. ANEMIA BILATERAL PLEURAL EFFUSION ESOPHAGEAL/GASTRIC CANDIDIASIS | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANEMIA BILATERAL PLEURAL EFFUSION ESOPHAGEAL/GASTRIC CANDIDIASIS | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER R. Small MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/13/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARBOR HOSP CTR - BALT MD | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | 32. REGISTRAR'S SIGNATURE L. R. Anderson-Randall | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10/10/10

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CECIL F. BURKE | | | | 2. DATE OF DEATH MONTH 05 DAY 15 YEAR 90 | | 3. TIME OF DEATH 5:30 P. M | |
| 4. SOCIAL SECURITY NUMBER 212-22-1932 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 63 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 07 23 26 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) 3842 QUARRY AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3842 QUARRY AVENUE | | 10f. ZIP CODE 21211 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9TH College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MECHANIC | | 16b. KIND OF BUSINESS/INDUSTRY CARPET | |
| 17. FATHER'S NAME (First, Middle, Last) ELMER B. BURKE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY BURKE | | | |
| 19a. INFORMANT'S NAME (Type/Print) ANNA BURKE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3842 QUARRY AVENUE, BALTIMORE, MD. 21211 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE A. Alan Seitz, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY A. ALAN SEITZ, JR. FUNERAL HOME 3818 Roland Avenue, Baltimore, Md. 21211 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung carcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death Monthly |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER A. Alan Seitz, Jr. | | | | 29c. LICENSE NUMBER 016965 | | 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B. A. Cochran, MD 846 W 36TH ST, BALD, MD 21211 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REPORT OF

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REPORT OF

REPORT OF

REPORT OF

90 13436

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH M. COUNTESS | | | | 2. DATE OF DEATH MONTH 5 - DAY 12 - YEAR 1990 | | 3. TIME OF DEATH 11:30 M | |
| 4. SOCIAL SECURITY NUMBER 219-34-0342 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-20-1914 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1700 MERIDENE DRIVE, APT. 205 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, CITY | | 9c. COUNTY OF DEATH MD. | |
| 10a. STATE MD. | | | | 10b. COUNTY BALTIMORE, CITY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, CITY | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1700 MERIDENE DRIVE | | | |
| 10f. ZIP CODE 21239 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) REGISTERED NURSE | | 16b. KIND OF BUSINESS/INDUSTRY HOSPITAL | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES W. POWERS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) NELLIE WILSON | | | |
| 19a. INFORMANT'S NAME (Type/Print) EDWARD W. COUNTESS JR. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1002 ADCOCK ROAD, LUTHERVILLE, MD. 21093 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) NEW CATHEDRAL CEM. | | 20c. LOCATION — City or Town, State BALTIMORE, MD. 21229 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. A. Butt | | | | 22. NAME AND ADDRESS OF FACILITY 4905 YORK ROAD 21212 H.W. JENKINS AND SONS CO. BALTO. MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death None |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Francis X. Carmondy |
| 29c. LICENSE NUMBER D01373 | | | | | | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS X. CARMONDY 201 EAST UNIVERSITY PKWY. BALTO. MD. 21218 | | | | | | | 31. DATE FILED (Month, Day, Year) MAY 18 1990 |
| 32. REGISTRAR'S SIGNATURE John Davidson | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) REBECCA CLANTON | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH 3:15 PM | |
| 4. SOCIAL SECURITY NUMBER 238-26-8021 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 02-2-14 | |
| 8. BIRTHPLACE (State or Foreign Country) N.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) HOMEWOOD HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | |
| 9c. COUNTY OF DEATH — | | | | 10a. STATE MD | | 10b. COUNTY — | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 604 CHESTNUT HILL AVE. | |
| 10f. ZIP CODE 21218 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 8th GRADE College (1-4 or 5+) — | | | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC | | 17. KIND OF BUSINESS/INDUSTRY — | |
| 17. FATHER'S NAME (First, Middle, Last) HENRY THORNES | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA TABER | | | |
| 19a. INFORMANT'S NAME (Type/Print) SHIRLEY GOLDSBOROUGH | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 CHESTNUT HILL BALTO, MD. 21218 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vanessa Coad | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Respiratory failure and ventilator dependent | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. COMATOSE with left ventricular mass | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. — | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Fleming | | | | 29c. LICENSE NUMBER D39489 | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HomeWood Hospital South | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 5-10-1990 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BARBARA E. COHEN | | | | 2. DATE OF DEATH MONTH 5 DAY 17 YEAR 1990 | | 3. TIME OF DEATH 5:45 P M | |
| 4. SOCIAL SECURITY NUMBER 212-22-7337 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 21, 1896 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore City | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5220 York Rd. | | | | 10f. ZIP CODE 21212 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) Unknown | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown Seebach | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Borgia M. Cohen | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4639 Harcourt Rd. Baltimore, Md. 21214 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland 5/21/90 | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Paul L. Hartsock, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Rd. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Brain Hypoxia | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Cardiac arrest | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| probably 2° to acute MI. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) NA | | 28b. TIME OF INJURY NA M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED NA | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NA | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) NA | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Harake MD | | | | 29c. LICENSE NUMBER D39663 | | 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mayet El-Harake MD The Union Memorial Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | 32. REGISTRAR'S SIGNATURE J. Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JENNIE CREHAN | | 2. DATE OF DEATH MONTH 05 DAY 15 YEAR 90 | | 3. TIME OF DEATH 2220 PM | |
| 4. SOCIAL SECURITY NUMBER 215-54-1704 T | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) 6/17/96 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| 9a. FACILITY NAME (If not Institution, give street and number) BALTIMORE COUNTY GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH RANDALLSTOWN | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION WOODLAWN | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 2023 N. ROLLING ROAD | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last) SAMUEL J. LEONARD | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BRIDGET SMITH | | | |
| 19a. INFORMANT'S NAME (Type/Print) EARL CREHAN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2023 N. ROLLING ROAD, WOODLAWN, MARYLAND 21207 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Linda K. Witzke</i> | | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Pulmonary Edema Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST atrial fibrillation with Rapid Ventricular Response atherosclerotic Cardiovascular Disease | | | | | Approximate Interval Between Onset and Death hours years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO NA |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED N/A | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Davidson</i> | | 29c. LICENSE NUMBER D27034 | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5310 OIO Court Rd Suite 201 Randallstown MD 21133 | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10/15/51



90 13440

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY J CARTER | | | | 2. DATE OF DEATH MONTH 5 DAY 6 YEAR 90 | | 3. TIME OF DEATH 1 P M | |
| 4. SOCIAL SECURITY NUMBER 218-30-7482 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-14-1912 | |
| 9a. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH BALTIMORE CITY | |
| 10a. STATE M.D. | | 10b. COUNTY BALTO. | | 10c. CITY, TOWN OR LOCATION BALTO. | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2121 WINDSOR GARDEN LANE | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 8+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Beautician | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Chester A. King | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Cosby Anderson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Kieth Allen | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Poplar Grove St. BALTO. M.D. 21217 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MT Auburn Cemetery BALTO. M.D. | | 20c. LOCATION — City or Town, State BALTO. M.D. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Universe L. Bell | | | | 22. NAME AND ADDRESS OF FACILITY Redd Funeral Service Monroe 1721 N | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → cardio pulmonary arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { a. Stroke b. Insulin Dependent Diabetes Mellitus c. Insulin Dependent Diabetes Mellitus d. Insulin Dependent Diabetes Mellitus | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 9 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 10 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Sher A Hashmi | | | | 29c. LICENSE NUMBER D24648 | | 29d. DATE SIGNED (Month, Day, Year) 5-6-1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHER HASHMI 2600 LIBERTY HEIGHTS Ave BALTIMORE 21215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE Sher A Hashmi | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13441

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN L. DOELLER | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-16-90 | | 3. TIME OF DEATH 11:30 A M | |
| 4. SOCIAL SECURITY NUMBER 212-05-9707 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-26-1911 | |
| 9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, CITY | | 9c. COUNTY OF DEATH | |
| 10a. STATE MD. | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, CITY | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 427 ROSEBANK AVE. | | 10f. ZIP CODE 21212 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALESMAN | | 16b. KIND OF BUSINESS/INDUSTRY OFFICE SUPPLIES | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN C. DOELLER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BERTHA STRUVEN | | | |
| 19a. INFORMANT'S NAME (Type/Print) DAVID L. DOELLER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20023 GORE MILL ROAD. FREELAND, MD. 21053 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) DRUID RIDGE CEM. | | 20c. LOCATION — City or Town, State PIKESVILLE, MD. 21208 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. G. Butte | | | | 22. NAME AND ADDRESS OF FACILITY 4905 YORK ROAD 21212 H.W. JENKINS AND SONS CO. BALTO, MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. ACUTE MYOCARDIAL INFARCTION | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. SEVERE ISCHEMIC CARDIOMYOPATHY | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. ASCVD | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Chak O. Lawrence | | | | 29c. LICENSE NUMBER D12399 | | 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Charles O'Donovan 9 E. Chase St. Baltimore, Md. 21202 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1951 57

90 13442

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>George I. Dixon</u> | | | | 2. DATE OF DEATH MONTH <u>05</u> DAY <u>17</u> YEAR <u>90</u> | | 3. TIME OF DEATH <u>4⁰⁰ A.M.</u> | |
| 4. SOCIAL SECURITY NUMBER <u>214-01-5466</u> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>83</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>06-03-06</u> | |
| 8. BIRTHPLACE (State or Foreign Country) <u>Baltimore</u> | | | | 9a. FACILITY NAME (If not institution, give street and number) <u>Mercy Hospital Center</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Balto. City, Md.</u> | |
| 9c. COUNTY OF DEATH ----- | | | | 10a. STATE <u>Md.</u> | | 10b. COUNTY ----- | |
| 10c. CITY, TOWN OR LOCATION <u>Baltimore</u> | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER <u>600 Light Street Apt. 301</u> | |
| 10f. ZIP CODE <u>21200</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: _____ | | | | 14. RACE — American Indian, Black, White, etc. Specify: <u>white</u> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5th Grade</u> College (1-4 or 5+) ----- | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Ice man</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>Own business</u> | |
| 17. FATHER'S NAME (First, Middle, Last) <u>George W. Dixon</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Myrtle --- King</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Mr. Gordon L. Norris</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>315 Stiemly Ave. Glen Burnie, Md. 21061</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____ | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Parkwood Cemetery</u> | | 20c. LOCATION — City or Town, State <u>Balto. Co. Md.</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Stanley M. Loewner</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Balto. Md. 21230</u> <u>McCully Funeral Home, 130 E. Fort Ave.</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>renal failure</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { a. <u>prastatic cancer</u> b. <u>hypertension</u> c. <u>hypertension</u> d. _____ PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>hypertension</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Stanley M. Loewner</u> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <u>5/17/90</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>301 St. Paul Place Baltimore, Md 21202</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>MAY 18 1990</u> | | | | 32. REGISTRAR'S SIGNATURE <u>John A. Davidson-Randall</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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90 13443

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Lawrence Edgar Dunnigan, Sr. | | | | 2. DATE OF DEATH MONTH 5 DAY 17 YEAR 90 | | 3. TIME OF DEATH 11:30 a.m. | |
| 4. SOCIAL SECURITY NUMBER 215-07-6339 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8-13-14 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 404 S. Calhoun Street | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH | | | | 10. RESIDENCE OF DECEDENT | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 404 S. Calhoun St. | | | | 10f. ZIP CODE 21223 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck driver | | 16b. KIND OF BUSINESS/INDUSTRY Construction | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Francis Dunnigan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dora Burton | | | |
| 19a. INFORMANT'S NAME (Type/Print) Jimmy Dunnigan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 S. Calhoun Street Baltimore, MD 21223 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Crestlawn Gardens of Memories | | 20c. LOCATION — City or Town, State Marriottsville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jackie D. Shannon | | | | 22. NAME AND ADDRESS OF FACILITY Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>cardio pulmonary arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>CAD</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>DM</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>.</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M. Welinsky M.D. | | | | 29c. LICENSE NUMBER D-27921 | | 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Welinsky 3411 Bank Street Baltimore, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE John A. Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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90 13444

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) THERESA DANA0 | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 14, 1990 | | | | 3. TIME OF DEATH 3:47 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 218-23-0400 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 25 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) April 20, 1965 | | 8. BIRTHPLACE (State or Foreign Country) Phillipines | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH BALTIMORE CITY | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Hyattsville | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 3704 Meadow Hill Rd. | | | | | | 10f. ZIP CODE 20785 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Asian - American | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4yrs. | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cashier | | | | 16b. KIND OF BUSINESS/INDUSTRY Private | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Benito Danao | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Bautista | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Victor Del Rosario | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3704 Meadow Hill Rd. Hyattsville, Md. 20785 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park | | | | 20c. LOCATION — City or Town, State Landover, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jimmy C. [Signature]</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, Md. 20785 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac arrest secondary hepatic failure/adult distress syndrome.</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | | Approximate Interval Between Onset and Death 5 min | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>MIAW</i> | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Catherine L. Kelleher</i> | | | | | | 29c. LICENSE NUMBER <i>A947</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>5/14/90</i> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CATHERINE L. KELLEHER, MD. 600 N WOLFE ST. BALTO. MD. 21205 / JHH | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 18 1990</i> | | | | 32. REGISTRAR'S SIGNATURE <i>J. Davidson [Signature]</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13445

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) FRANK DIPASQUALE | | | | 2. DATE OF DEATH MONTH 05 DAY 17 YEAR 90 | | 3. TIME OF DEATH 7²⁵ P.M. | |
| 4. SOCIAL SECURITY NUMBER 218-42-4081 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-29-15 | |
| 8. BIRTHPLACE (State or Foreign Country) West Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE Md. | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 6404 Rosemont Avenue | |
| 10f. ZIP CODE 21206 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Factory | | 16b. KIND OF BUSINESS/INDUSTRY T.J. Schwartz | |
| 17. FATHER'S NAME (First, Middle, Last) Luigi Di Pasquale | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Caccamo | | | |
| 19a. INFORMANT'S NAME (Type/Print) Rosa DiPasquale | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6404 Rosemont Avenue - Baltimore, Md. - 21206 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen M. Murphy</i> | | | | 22. NAME AND ADDRESS OF FACILITY John C. Miller Inc. 6415 Belair Road Baltimore, Md. - 21206 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Biliary Sepsis a. DUE TO (OR AS A CONSEQUENCE OF): b. Biliary obstruction DUE TO (OR AS A CONSEQUENCE OF): c. metastatic squamous cell Ca of Rt Urinary tract DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Azar MD - house officer.</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print) R. Azar - Good Samaritan Hospital - Baltimore MD - 21239. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|----------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Cecil G. Dietz | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 16 1990 | | 3. TIME OF DEATH 2 35 8 M | | | |
| 4. SOCIAL SECURITY NUMBER 219-56-3392 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 25, 1912 | | 8. BIRTHPLACE (State or Foreign Country) Md. | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Joseph Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | | 9c. COUNTY OF DEATH Baltimore | | |
| 10a. STATE Md. | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2610 Windsor Road | | | | 10f. ZIP CODE 21234 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Clinton C. Giese | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Cecil Hill | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Frederick G. Dietz | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2610 Windsor Road Baltimore, Md. 21234 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount May 17, 1990 | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Gladden <i>James F. Gladden</i> | | | | 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Inc. 5305 Harford Rd. 21214 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>L. L. D. D. MD.</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>May 17 '90</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>L. L. D. D.</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01/15/19

90 13447

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) KATHRYN MARY EARP | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-17-90 | | 3. TIME OF DEATH 0210 AM | |
| 4. SOCIAL SECURITY NUMBER 215-01-3640 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 72 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 4-4-1918 | | 8. BIRTHPLACE (State or Foreign Country) MD. | |
| 9a. FACILITY NAME (If not institution, give street and number) G.B.M.C. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, CITY | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 823 EAST LAKE AVE. | | | | 10f. ZIP CODE 21212 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OFFICE | | 16b. KIND OF BUSINESS/INDUSTRY C. AND P. PHONE CO. | | | |
| 17. FATHER'S NAME (First, Middle, Last) GEORGE W. BAYLEY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH MUTHAAPT | | | |
| 19a. INFORMANT'S NAME (Type/Print) JOAN KLEIN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8700 SUMMIT AVE. PARKVILLE, MD. 21234 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MD. 21234 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edison M. Perkins Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY 4905 YORK ROAD 21212 H.W. JENKINS AND SONS CO. BALTO, MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → LUNG CANCER, RT Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { a. DUE TO (OR AS A CONSEQUENCE OF): MYOCARDIAL INFARCT b. DUE TO (OR AS A CONSEQUENCE OF): RESPIRATORY FAILURE c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 5-17-90 | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Cerino, MD</i> | | 29c. LICENSE NUMBER DO3607 | | 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Michele T. Cerino 7600 Osler Drive Baltimore, Md. 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WAGE 12

90 13448

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lola W. Ellis | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 17 90 | | 3. TIME OF DEATH 1:50 PM | |
| 4. SOCIAL SECURITY NUMBER 220-14-3480 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 7, 1906 | |
| 9a. FACILITY NAME (If not institution, give street and number) Pleasant Manor Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH City | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Belair | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 718 Fairwind Drive | | | | 10f. ZIP CODE 21014 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <input checked="" type="checkbox"/> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) - | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) - | | | |
| 19a. INFORMANT'S NAME (Type/Print) Carol Lipka | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 718 Fairwind Drive Belair, Md. 21014 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Mem. May 19, 1990 | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Gladden | | | | 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Inc. 5305 Harford Rd. 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiorespiratory Arrest | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): Generalized ASCVD | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Electrolyte Imbalance Renal Failure | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER James F. Gladden MD | | | | 29c. LICENSE NUMBER D5124 | | 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5314 Harford Rd. Balt. MD. 21214 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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90 13449

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) MARGUERITE FLOYD / Marguerite Louise Floyd | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 90 | | 3. TIME OF DEATH 1:30 P M | |
| 4. SOCIAL SECURITY NUMBER 220-30-5355 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7-2-11 | |
| 9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH MD | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, CITY | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 602 LEAFYDALE TERRACE | | | | 10f. ZIP CODE 21208 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (1-12) 6th GRADE College (1-4 or 5+) HOUSEWIFE | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN WALKER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) REBECCA LEWIS | | | |
| 19a. INFORMANT'S NAME (Type/Print) REBECCA E. FLOYD | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 LEAFYDALE TER. BALTO, MD. 21208 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PK. | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vanessa Coad | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Renal Failure DUE TO (OR AS A CONSEQUENCE OF): b. DM + HTN DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 1 Year 20 Years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. clostridium Difficile Anemia | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER James A. Coomes M.D. | | | | 29c. LICENSE NUMBER N/A | | 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James A Coomes M.D. 201 E Univ PKwy Baltimore, Md. 21218 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00 13443

90 13450

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary Giovannis | | | | 2. DATE OF DEATH MONTH 05 DAY 16 YEAR 90 | | 3. TIME OF DEATH 11:25 AM | |
| 4. SOCIAL SECURITY NUMBER 214-30-3728 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06/24/05 | |
| 8. BIRTHPLACE (State or Foreign Country) MD | | | | 9a. FACILITY NAME (If not institution, give street and number) St. Joseph Hosp. Tal-7620 York Rd | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Md. | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 4903 Harford Road | |
| 10f. ZIP CODE 21214 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) none | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) none | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Nicholas K. Giovannis | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Tuski | | | |
| 19a. INFORMANT'S NAME (Type/Print) Florida Giovannis | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4903 Harford Road Baltimore, Md. 21214 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn May 18, 1990 | | | |
| 20c. LOCATION — City or Town, State Woodlawn, Md. | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Gladden | | | |
| 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Inc. 5305 Harford Rd. 21214 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. END STAGE CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER John H. L. Ruck | | | |
| 29c. LICENSE NUMBER 033215 | | | | 29d. DATE SIGNED (Month, Day, Year) 05/16/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

02/10/20

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13451

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN HAMILTON | | | | 2. DATE OF DEATH MONTH 5 DAY 15 YEAR 90 | | 3. TIME OF DEATH 7:30 AM | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-73-8275 | | 6. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-25-19 | | 8. BIRTHPLACE (State or Foreign Country) North Carolina | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Church Home Hosp. / FARMONT | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore Md. | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 2722 Ashland Ave. | | | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JACOB HAMILTON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BEULAH GRIMES | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) DOROTHY HAMILTON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2722 ASHLAND AVE. BALTO, MD. 21205 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vanessa Coad | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARCINOMA OF COLON WITH METASTASES TO LIVER & LYMPH GLANDS Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEIZURES | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Curran MD | | | | 29c. LICENSE NUMBER D16619 | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. VERGARA - SOARES, M.D. 100 N. BROADWAY BALTO. MD. 21251 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RICHARD D JONES | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 15 1990 | | 3. TIME OF DEATH 7:22 P M | |
| 4. SOCIAL SECURITY NUMBER 218-60-7730 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 37 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-31-52 | |
| 8a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 8c. COUNTY OF DEATH BALTIMORE CITY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, MD. | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1506 E. CHASE ST. | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 7th GRADE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BALTIMORE CITY PUBLIC WORKS | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES STEWART | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CLARICE JONES | | | |
| 19a. INFORMANT'S NAME (Type/Print) VONDALAIR Y. JONES | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1506 E. CHASE ST. BALTO, MD. 21213 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MT. CALVARY CEMETERY | | 20c. LOCATION — City or Town, State ANNE ARUNDEL CO, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vanessa Coal | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia</u> | | | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| b. <u>AIDS</u> | | | | | | | |
| c. <u>Acute Failure</u> | | | | | | | |
| d. <u>Acute Failure</u> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Acute Failure</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Joshua Hare MD, Junior Resident | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joshua Hare, Johns Hopkins Hospital, Dept. of Medicine, Baltimore, MD 21205 | | | | | | | |
| 31. DATE FILED MAY 18 1990 | | 32. REGISTRAR'S SIGNATURE Joshua Hare | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7. 12. 55

90 13453

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LILLIAN LOUISE JOHNSON | | | | 2. DATE OF DEATH MONTH May DAY 15 YEAR 1990 | | 3. TIME OF DEATH 6:05 P. M. | |
| 4. SOCIAL SECURITY NUMBER 221-63-7362 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 18, 1921 | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Mary's Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Leonardtowntown | | | | 9c. COUNTY OF DEATH St. Mary's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Saint Mary's County | | 10c. CITY, TOWN OR LOCATION Lexington Park | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 300 Lexwood Drive Apt. 313A | | | | 10f. ZIP CODE 20653 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Registered Nurse | | 16b. KIND OF BUSINESS/INDUSTRY Sheppard Pratt Hospital | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Denton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Evelyn Elliott Denton Sterling | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ms. Colleen Marone | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Catherine Court, Hillsdale, New Jersey 07642 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin E. Ecker | | | | 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiopulmonary Arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. End Stage I Ischemic Coronaryopathy c. d. e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. y. z. aa. ab. ac. ad. ae. af. ag. ah. ai. aj. ak. al. am. an. ao. ap. aq. ar. as. at. au. av. aw. ax. ay. az. ba. bb. bc. bd. be. bf. bg. bh. bi. bj. bk. bl. bm. bn. bo. bp. bq. br. bs. bt. bu. bv. bw. bx. by. bz. ca. cb. cc. cd. ce. cf. cg. ch. ci. cj. ck. cl. cm. cn. co. cp. cq. cr. cs. ct. cu. cv. cw. cx. cy. cz. da. db. dc. dd. de. df. dg. dh. di. dj. dk. dl. dm. dn. do. dp. dq. dr. ds. dt. du. dv. dw. dx. dy. dz. ea. eb. ec. ed. ee. ef. eg. eh. ei. ej. ek. el. em. en. eo. ep. eq. er. es. et. eu. ev. ew. ex. ey. ez. fa. fb. fc. fd. fe. ff. fg. fh. fi. fj. fk. fl. fm. fn. fo. fp. fq. fr. fs. ft. fu. fv. fw. fx. fy. fz. ga. gb. gc. gd. ge. gf. gg. gh. gi. gj. gk. gl. gm. gn. go. gp. gq. gr. gs. gt. gu. gv. gw. gx. gy. gz. ha. hb. hc. hd. he. hf. hg. hh. hi. hj. hk. hl. hm. hn. ho. hp. hq. hr. hs. ht. hu. hv. hw. hx. hy. hz. ia. ib. ic. id. ie. if. ig. ih. ii. ij. ik. il. im. in. io. ip. iq. ir. is. it. iu. iv. iw. ix. iy. iz. ja. jb. jc. jd. je. jf. jg. jh. ji. jj. jk. jl. jm. jn. jo. jp. jq. jr. js. jt. ju. jv. jw. jx. jy. jz. ka. kb. kc. kd. ke. kf. kg. kh. ki. kj. kl. km. kn. ko. kp. kq. kr. ks. kt. ku. kv. kw. kx. ky. kz. la. lb. lc. ld. le. lf. lg. lh. li. lj. lk. ll. lm. ln. lo. lp. lq. lr. ls. lt. lu. lv. lw. lx. ly. lz. ma. mb. mc. md. me. mf. mg. mh. mi. mj. mk. ml. mm. mn. mo. mp. mq. mr. ms. mt. mu. mv. mw. mx. my. mz. na. nb. nc. nd. ne. nf. ng. nh. ni. nj. nk. nl. nm. nn. no. np. nq. nr. ns. nt. nu. nv. nw. nx. ny. nz. oa. ob. oc. od. oe. of. og. oh. oi. oj. ok. ol. om. on. oo. op. oq. or. os. ot. ou. ov. ow. ox. oy. oz. pa. pb. pc. pd. pe. pf. pg. ph. pi. pj. pk. pl. pm. pn. po. pp. pq. pr. ps. pt. pu. pv. pw. px. py. pz. qa. qb. qc. qd. qe. qf. qg. qh. qi. qj. qk. ql. qm. qn. qo. qp. qq. qr. qs. qt. qu. qv. qw. qx. qy. qz. ra. rb. rc. rd. re. rf. rg. rh. ri. rj. rk. rl. rm. rn. ro. rp. rq. rr. rs. rt. ru. rv. rw. rx. ry. rz. sa. sb. sc. sd. se. sf. sg. sh. si. sj. sk. sl. sm. sn. so. sp. sq. sr. ss. st. su. sv. sw. sx. sy. sz. ta. tb. tc. td. te. tf. tg. th. ti. tj. tk. tl. tm. tn. to. tp. tq. tr. ts. tu. tv. tw. tx. ty. tz. ua. ub. uc. ud. ue. uf. ug. uh. ui. uj. uk. ul. um. un. uo. up. uq. ur. us. ut. uu. uv. uw. ux. uy. uz. va. vb. vc. vd. ve. vf. vg. vh. vi. vj. vk. vl. vm. vn. vo. vp. vq. vr. vs. vt. vu. vv. vw. vx. vy. vz. wa. wb. wc. wd. we. wf. wg. wh. wi. wj. wk. wl. wm. wn. wo. wp. wq. wr. ws. wt. wu. wv. ww. wx. wy. wz. xa. xb. xc. xd. xe. xf. xg. xh. xi. xj. xk. xl. xm. xn. xo. xp. xq. xr. xs. xt. xu. xv. xw. xx. xy. xz. ya. yb. yc. yd. ye. yf. yg. yh. yi. yj. yk. yl. ym. yn. yo. yp. yq. yr. ys. yt. yu. yv. yw. yx. yy. yz. za. zb. zc. zd. ze. zf. zg. zh. zi. zj. zk. zl. zm. zn. zo. zp. zq. zr. zs. zt. zu. zv. zw. zx. zy. zz. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER David M. Federle MD | | | | 29c. LICENSE NUMBER D34198 | | 29d. DATE SIGNED (Month, Day, Year) 5/16/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David Federle, M.D., Mechanicsville, Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

12 3456

2281

ITEMS:23pt1,part2,27 per ME

90 13454

FOR
STATE
REGISTRAR 6-18-90 cmSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Roger Judson Jeffries | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-16-90 | | 3. TIME OF DEATH 4:10PM M | |
| 4. SOCIAL SECURITY NUMBER 213-58-0894 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 39 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 04-01-51 | |
| 8. BIRTHPLACE (State or Foreign Country) Massachusetts | | | | 9a. FACILITY NAME (If not institution, give street and number) 1901 W. North Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH none | | | | 10a. STATE Maryland | | 10b. COUNTY none | |
| 10c. CITY, TOWN OR LOCATION Baltimore City | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2024 N. Washington Street | |
| 10f. ZIP CODE 21213 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Negroid | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 2years | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self Employed | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Judson L. Jeffries | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Brightman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Judson L. Jeffries | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2024 N. Washington St. Balto, Md. 21213 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Ebenezer Bapt. Ch. Cemetery/Culpeper, Virginia | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs Sr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS, CONGENITAL BICUSPID AORTIC VALVE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia C. Goodin, MD</i> | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-17-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julia C. Goodin, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia C. Goodin</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13455

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROGER D. KUHLEMAN | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 16 90 | | 3. TIME OF DEATH 7:15 P M | |
| 4. SOCIAL SECURITY NUMBER 319-38-2741 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 45 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 09/27/44 | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, Maryland | | 9c. COUNTY OF DEATH -- | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Catonsville | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1410 Glenwilde Road | | | | 10f. ZIP CODE 21228 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No -- If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE -- American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Specify kind of work done during most of working life. Do NOT use retired.) AGENT | | 16b. KIND OF BUSINESS/INDUSTRY F.B.I. | |
| 17. FATHER'S NAME (First, Middle, Last) LYMAN KUHLEMAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LOVELLA SHAY | | | |
| 19a. INFORMANT'S NAME (Type/Print) KATHY KUHLEMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1410 GLENWILDE ROAD, CATONSVILLE, MARYLAND 21228 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) CRESTLAWN CEMETERY | | 20c. LOCATION -- City or Town, State MARRIOTTSTVILLE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| NON-SMALL CELL CARCINOMA OF THE LUNG WITH | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| METASTASES TO REGIONAL LYMPH NODES AND LEFT | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PARIETAL PLEURA WITH EFFUSION | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DQA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY -- At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D09990 | | 29d. DATE SIGNED (Month, Day, Year) 05/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael E. Pelczar, M.D., St. Agnes Hospital, Department of Pathology | | | | | | | |
| 31. DATE (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

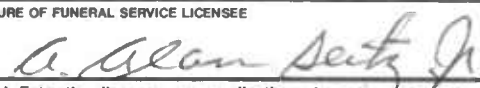

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

56 10823

90 13456

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) Jon F. Knott Sr. | | | | 2. DATE OF DEATH MONTH DAY YEAR May 16, 1990 | | 3. TIME OF DEATH 10:00 A M | |
| 4. SOCIAL SECURITY NUMBER 213-32-3099 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 55 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 06 19 34 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEASED | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION EDGEWOOD | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1440 HARFORD SQUARE DRIVE | | | | 10f. ZIP CODE 21040 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12TH College (1-4 or 5+) College | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SUPERVISOR | | 16b. KIND OF BUSINESS/INDUSTRY ENVIRONMENTAL SERVICES | | | |
| 17. FATHER'S NAME (First, Middle, Last) BRIZILLIA GEORGE FRANCIS KNOTT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LORA I. LOVELL | | | |
| 19a. INFORMANT'S NAME (Type/Print) FREELOVE KNOTT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1440 HARFORD SQUARE DRIVE, EDGEWOOD, MD. 21040 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY A. ALAN SEITZ, JR. FUNERAL HOME 3818 ROLAND AVENUE, BALTIMORE, MD. 21211 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death | |
| a. Cerebrovascular occlusion DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Atherosclerotic Cardio Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Francis A. Clark, Jr. M.D. | | | | 29c. LICENSE NUMBER D02044 | | 29d. DATE SIGNED (Month, Day, Year) 5-16-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS A. CLARK, JR., M.D. c/o Maryland General Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

001 1 20

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RICHARD L. LIMBURG Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 17 1990 | | 3. TIME OF DEATH 6:45 a.m. M | |
| 4. SOCIAL SECURITY NUMBER 151-30-8849 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 50 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3/11/1940 | |
| 8. BIRTHPLACE (State or Foreign Country) Ohio | | | | 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | |
| 9c. COUNTY OF DEATH BALTIMORE CITY | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY A.A.Co. | | 10c. CITY, TOWN OR LOCATION Millersville, Md. | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 8184 Weyburn Rd. | | | | 10f. ZIP CODE 21108 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th. Grade College (1-4 or 5+) 4 YEARS | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Inspector | | 16b. KIND OF BUSINESS/INDUSTRY John J. Heyn Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Richard L. Limburg, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Wilma --- Becker | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Janice Limburg | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8184 Weyburn Rd. Millersville, Md. 21108 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | 20c. LOCATION — City or Town, State Catonsville, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Daniel A. Taylor</i> | | | | 22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Right Ventricular Rupture DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death 40 min | |
| | | b. myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): | | | | 48 hrs. | |
| | | c. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Steven A. O'Day JAR medicine</i> | | | | 29c. LICENSE NUMBER AA298 | | 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Steven John O'Day Johns Hopkins Hosp. Balt/MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | 32. REGISTRAR'S SIGNATURE <i>John A. Anderson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12:22 PM

12:22 PM

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DAVID LUCAS | | | | | | | | 2. DATE OF DEATH MONTH 5 - DAY 14 - YEAR 90 | | | | 3. TIME OF DEATH 8 40 P M | | | |
| 4. SOCIAL SECURITY NUMBER 217-38-6549 | | | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 47 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) August 2, 1942 Maryland | | 8. BIRTHPLACE (State or Foreign Country) | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Greater Laurel Beltsville Hospital | | | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Laurel | | | | 9c. COUNTY OF DEATH P.G. | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Prince George's | | | | 10c. CITY, TOWN OR LOCATION Laurel | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 610 Main Street | | | | | | | | 10f. ZIP CODE 20707 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter | | | | 16b. KIND OF BUSINESS/INDUSTRY Private | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Lucas | | | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Powell | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Tina Cross | | | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1218 Garrisonville Rd. #201 Stafford, Va. 22554 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Crematory | | | | 20c. LOCATION — City or Town, State Suitland, Maryland | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jimmy C. Neal Jr.</i> | | | | | | | | 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, Maryland 20785 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Advanced alcoholic Liver Disease DUE TO (OR AS A CONSEQUENCE OF): b. Severe hypoproteinemias DUE TO (OR AS A CONSEQUENCE OF): c. Pulmonary edema DUE TO (OR AS A CONSEQUENCE OF): d. ANEMIA, sepsis Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | Approximate Interval Between Onset and Death YEARS Months Days DAYS | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia, malnutrition, Coagulopathy due to Liver Disease | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NA | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Pritham S Saini | | | | 29c. LICENSE NUMBER D28998 | | 29d. DATE SIGNED (Month, Day, Year) 5-15-90 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PRITHAM S SAINI 9101 CHERRY LN #211 LAUREL MD 20708 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | | | | | |

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARSHALL BRENDEN THOMAS (BABY THOMAS 'B') | | | | 2. DATE OF DEATH MONTH 5 DAY 18 YEAR 90 | | 3. TIME OF DEATH 0340 | |
| 4. SOCIAL SECURITY NUMBER — | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 6 days | | 7. DATE OF BIRTH (Month, Day, Year) 5-12-90 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL | | | |
| 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, MD. | | | | 9c. COUNTY OF DEATH — | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY — | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4139 HAGUE AVE. | | 10f. ZIP CODE 21225 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) — College (1-4 or 5+) — | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) GUY E. THOMAS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ANGELA THOMAS Bruce | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Guy E. Thomas | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4139 Hague Ave. Balto. Md. 21225 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Mem. Park | | 20c. LOCATION — City or Town, State Md. Elkridge, Howard Co. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Daniel A. Taylor | | | | 22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. HYALINE MEMBRANE DISEASE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. EXTREME PREMATURITY DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MULTIPLE PNEUMOTHORACES | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Susan M. Schapiro MD | | | | 29c. LICENSE NUMBER D2450 | | 29d. DATE SIGNED (Month, Day, Year) 5/18/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Susan M. Schapiro MD, St. Agnes Hospital, 900 Caton Ave., Baltimore MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Rendall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) MAMIE ELIZABETH MARSIGLIA | | | | 2. DATE OF DEATH MONTH 5 DAY 16 YEAR 90 | | 3. TIME OF DEATH 405 P M | |
| 4. SOCIAL SECURITY NUMBER 219-07-1730 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 69 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 6/9/20 | | 8. BIRTHPLACE (State or Foreign Country) Virginia | |
| 9a. FACILITY NAME (If not institution, give street and number) Mercy Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 316 South Payson Street | | 10f. ZIP CODE 21223 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) George B. Harrison | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Lee Lawson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Betty Rice | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 253 Glen Gary Garth Glen Burnie, MD 21061 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park | | 20c. LOCATION — City or Town, State Elkridge, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn F. Fisher | | | | 22. NAME AND ADDRESS OF FACILITY Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory failure DUE TO (OR AS A CONSEQUENCE OF): Carcinoma of the lung (oat cell) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Supraventricular tachycardia congestive heart failure | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Mamie J. Feldman | | | | 29c. LICENSE NUMBER D7830 | | 29d. DATE SIGNED (Month, Day, Year) 5-16-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARVIN J. FELDMAN, MD. 301 ST. Paul Place Baltimore 21202 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE Julia F. Fisher | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20001 FM

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Dorothy L. Maas</i> | | | | 2. DATE OF DEATH MONTH <i>5</i> DAY <i>12</i> YEAR <i>90</i> | | 3. TIME OF DEATH <i>0458</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>212-20-3891</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 5. AGE (In yrs. last birthday) <i>66</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>2/19/24</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>North Arundel Hosp</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Glen Burnie</i> | | 9c. COUNTY OF DEATH <i>AA</i> | |
| 10a. STATE <i>MD.</i> | | 10b. COUNTY <i>Anne Arundel</i> | | 10c. CITY, TOWN OR LOCATION <i>Glen Burnie</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>12 Queen Anne Road</i> | | | | 10f. ZIP CODE <i>21061</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>10th Grade</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Domestic</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Raymond Lewis Boston</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Gladys May Reinhart</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Joseph B. Maas</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12 Queen Anne Road; Glen Burnie, Md. 21061</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Belair Mem. Gardens</i> | | 20c. LOCATION — City or Town, State <i>Belair, Maryland</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Hackman Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>McCully Funeral Home 237 E. Patapsco Ave. Balto., Md.</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pulmonary Embolism</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>William P. Jones, MD Deputy</i> | | | | 29c. LICENSE NUMBER <i>D06054</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>5/12/90</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>William P. Jones, MD 695 America 21035</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 18 1990</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Rendell</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

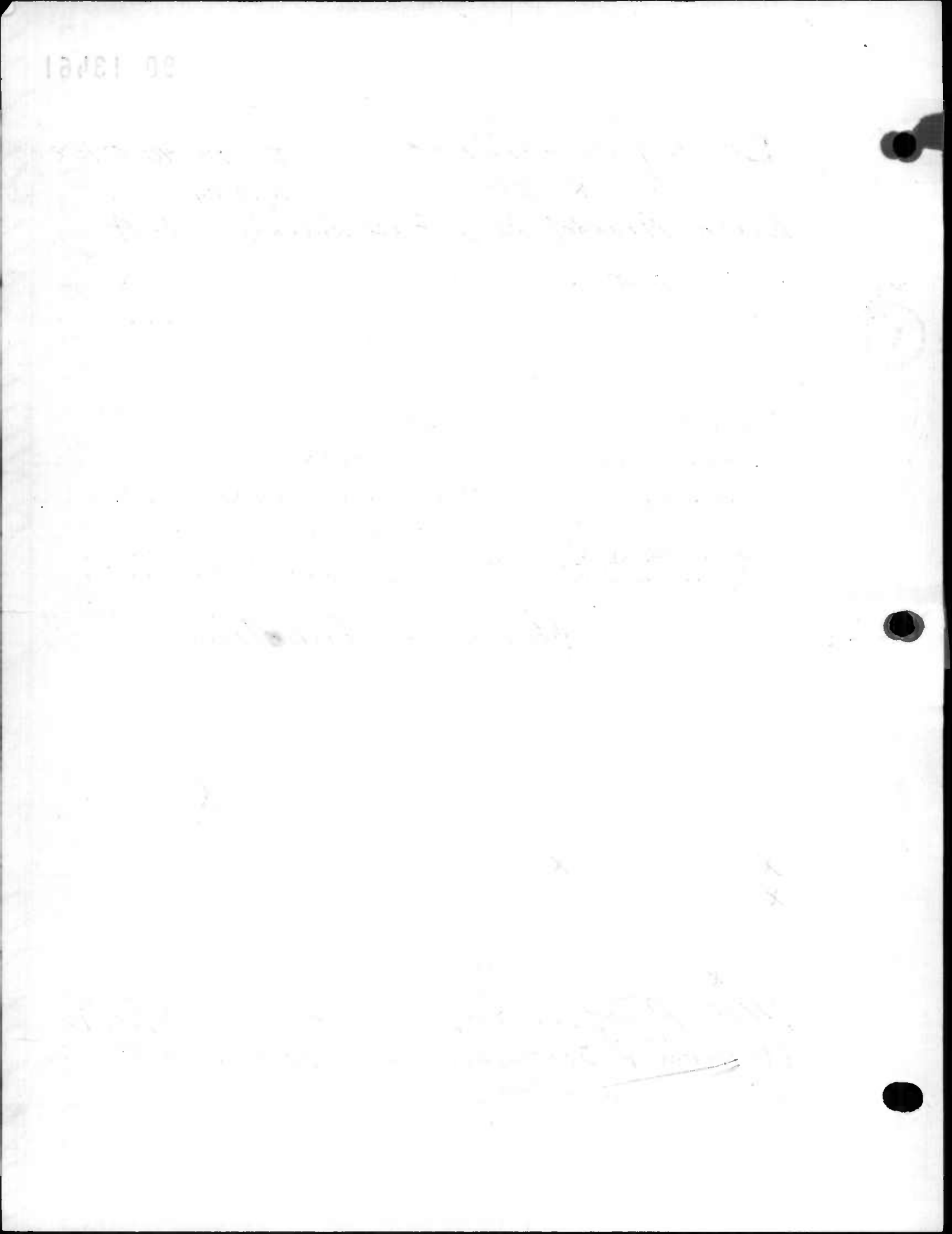
DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALTIMORE, MARYLAND 21203-1146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT MEEK Robert Meek | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 5 17 17 90 | | 3. TIME OF DEATH 7:30 A M | |
| 4. SOCIAL SECURITY NUMBER 219-10-2910 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12 12 1925 | |
| 8. BIRTHPLACE (State or Foreign Country) Md. | | | | 9a. FACILITY NAME (If not institution, give street and number) HOMEWOOD HOSPITAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE MD | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE Md. | | | |
| 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION Balto. | | | |
| 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | 10e. STREET AND NUMBER 123 W. 29th St. | | | |
| 10f. ZIP CODE 21218 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Security Guard | | 16b. KIND OF BUSINESS/INDUSTRY Burns Agency | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Meek Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Kauffman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Dobbs | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 Old Home Rd. Balto., Md. 21206 | | | |
| 20a. METHOD OF DISPOSITION 1 BURIAL 2 CREMATION 3 REMOVAL FROM STATE 4 DONATION 5 OTHER (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Balto. Cem. | | 20c. LOCATION — City or Town, State Balto., Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY John C. Miller Inc. 6415 Belair Rd. Balto., Md. 21206 | | | |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute renal failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST End stage COPD (EMPHYSEMA) Pneumonia | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Jerano L. Lamb Hospital Physician | | | | 29c. LICENSE NUMBER D37203 | | 29d. DATE SIGNED (Month, Day, Year) 5-17-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) TERANCE L. LAMB MD HOMEWOOD HOSPITAL | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

03 1985

U.S. DEPARTMENT OF AGRICULTURE
NATIONAL AGRICULTURAL MECHANIZATION SERVICE
COTTON COUNCIL

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

07/21/00

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ALLEN FORREST MACNEILL | | | | 2. DATE OF DEATH MONTH DAY YEAR May 9 1990 | | 3. TIME OF DEATH 4:48 A.M. | |
| 4. SOCIAL SECURITY NUMBER 428-98-3395 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 43 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-13-1946 | |
| 8a. FACILITY NAME (If not institution, give street and number) Andrews Air Force Base | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Suitland | | 8c. COUNTY OF DEATH Prince George's | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Del. | | 10b. COUNTY Kent | | 10c. CITY, TOWN OR LOCATION 110 N. Fairfield Dr. Dover, Del. | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 110 N. Fairfield Dr. | | | | 10f. ZIP CODE 19901 | | 10g. CITIZEN OF WHAT COUNTRY? U S | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maj. U S Air Force | | 16b. KIND OF BUSINESS/INDUSTRY U S Air Force | | | |
| 17. FATHER'S NAME (First, Middle, Last) Barton W. MacNeill | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jean Turner | | | |
| 19a. INFORMANT'S NAME (Type/Print) Shirley R. MacNeill | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 N. Fairfield Dr., Dover, Del. 19901 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National | | 20c. LOCATION — City or Town, State Arlington, Va. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas R. Trader</i> | | | | 22. NAME AND ADDRESS OF FACILITY Trader Funeral Home Inc. 12 Lotus St. Dover, Del. 19901 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Upper GI Bleed DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. Pancreatic Cancer DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mary Beth Kerr, MD</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) May 9, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARY BETH KERR, CAPT, USAF, MC | | | | MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB MD 20331-5300 | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a summary of the work done during the past year. It includes a list of the projects completed and a brief description of the results obtained. The second part of the report is a detailed account of the work done on the project entitled "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate".

The work was done by the following persons: J. H. Smith, J. E. Jones, and J. A. Brown. The work was done in the laboratory of the Department of Chemistry, University of California, Los Angeles.

The work was done during the period from January 1, 1959, to December 31, 1959. The work was done in the laboratory of the Department of Chemistry, University of California, Los Angeles.

The work was done in the laboratory of the Department of Chemistry, University of California, Los Angeles. The work was done during the period from January 1, 1959, to December 31, 1959. The work was done in the laboratory of the Department of Chemistry, University of California, Los Angeles.

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The work was done in the laboratory of the Department of Chemistry, University of California, Los Angeles. The work was done during the period from January 1, 1959, to December 31, 1959. The work was done in the laboratory of the Department of Chemistry, University of California, Los Angeles.

90 13465

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | |
|--|---|---|--|---|--|---|----------------------------------|---|------------------------|--------------|---------------------------|--------------|
| 1. DECEDENT'S NAME (First, Middle, Last) CARRIE J Mc QUAY | | | | 2. DATE OF DEATH MONTH 5 DAY 17 YEAR 90 | | 3. TIME OF DEATH M | | | | | | |
| 4. SOCIAL SECURITY NUMBER 217-16-6600 | | 6. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-19-19 | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 827 ARLINGTON Ave. | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH | | | | | | |
| 10a. STATE M.D. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTO | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | |
| 10e. STREET AND NUMBER 827 ARLINGTON Ave. | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. BLACK | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MAINTENANCE | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Alexander Ross | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Colbert | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Irving McQuay | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 827 ARLINGTON Ave. BALTO MD 21217 | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MT ZION cemetery | | 20c. LOCATION — City or Town, State BALTO M.D. | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Monroe L. Reed | | | | 22. NAME AND ADDRESS OF FACILITY Redd Funeral Service MonRoet St. 1721 N. | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SUSPECTED ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="1"> <tr> <td>a. ISCHEMIC HEART DISEASE</td> <td>Approximate Interval Between Onset and Death 1 MM</td> </tr> <tr> <td>b. HYPERTENSION</td> <td>YEARS</td> </tr> <tr> <td>c. ATHEROSCLEROSIS</td> <td>YEARS</td> </tr> </table> | | | | | | | a. ISCHEMIC HEART DISEASE | Approximate Interval Between Onset and Death 1 MM | b. HYPERTENSION | YEARS | c. ATHEROSCLEROSIS | YEARS |
| a. ISCHEMIC HEART DISEASE | Approximate Interval Between Onset and Death 1 MM | | | | | | | | | | | |
| b. HYPERTENSION | YEARS | | | | | | | | | | | |
| c. ATHEROSCLEROSIS | YEARS | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIBASES MYELITIS, CHRONIC RENAL FAILURE | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Charles Rosenfeld, MD | | | | 29c. LICENSE NUMBER D31301 | | 29d. DATE SIGNED (Month, Day, Year) 5/16/90 | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES ROSENFELD, MD 700 WASHINGTON BLVD BALTO, MD 21201 | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13466

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM McREDDON MYERS, JR. | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 16 90 | | 3. TIME OF DEATH 0950 A M | |
| 4. SOCIAL SECURITY NUMBER 214-20-7431 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 63 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 7-30-26 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) FRANCIS SCOTT KEY MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION ESSEX | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 909 LUTZ AVENUE | | 10f. ZIP CODE 21221 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE College (1-4 or 5+) N/A | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ROUTE SUPERVISOR | | | | 16b. KIND OF BUSINESS/INDUSTRY SALES | | 17. FATHER'S NAME (First, Middle, Last) WILLIAM M. MYERS | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) GLADYS RHODES | | | | 19a. INFORMANT'S NAME (Type/Print) CHRISTINE B. MYERS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 LUTZ AVENUE BALTIMORE, MARYLAND 21219 | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL 5-19-1990 | | 20c. LOCATION — City or Town, State DORSEY, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | a. Cardiac arrest | | Approximate Interval Between Onset and Death | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | b. Respiratory failure | | | |
| | | | | c. Metastatic cancer disseminated carcinoma. | | | |
| | | | | d. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER D. Davidson-Randall MD | | 29c. LICENSE NUMBER D29585 | |
| 29d. DATE SIGNED (Month, Day, Year) 5/16/90 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | 31. DATE FILED (Month, Day, Year) MAY 18 1990 | |
| 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

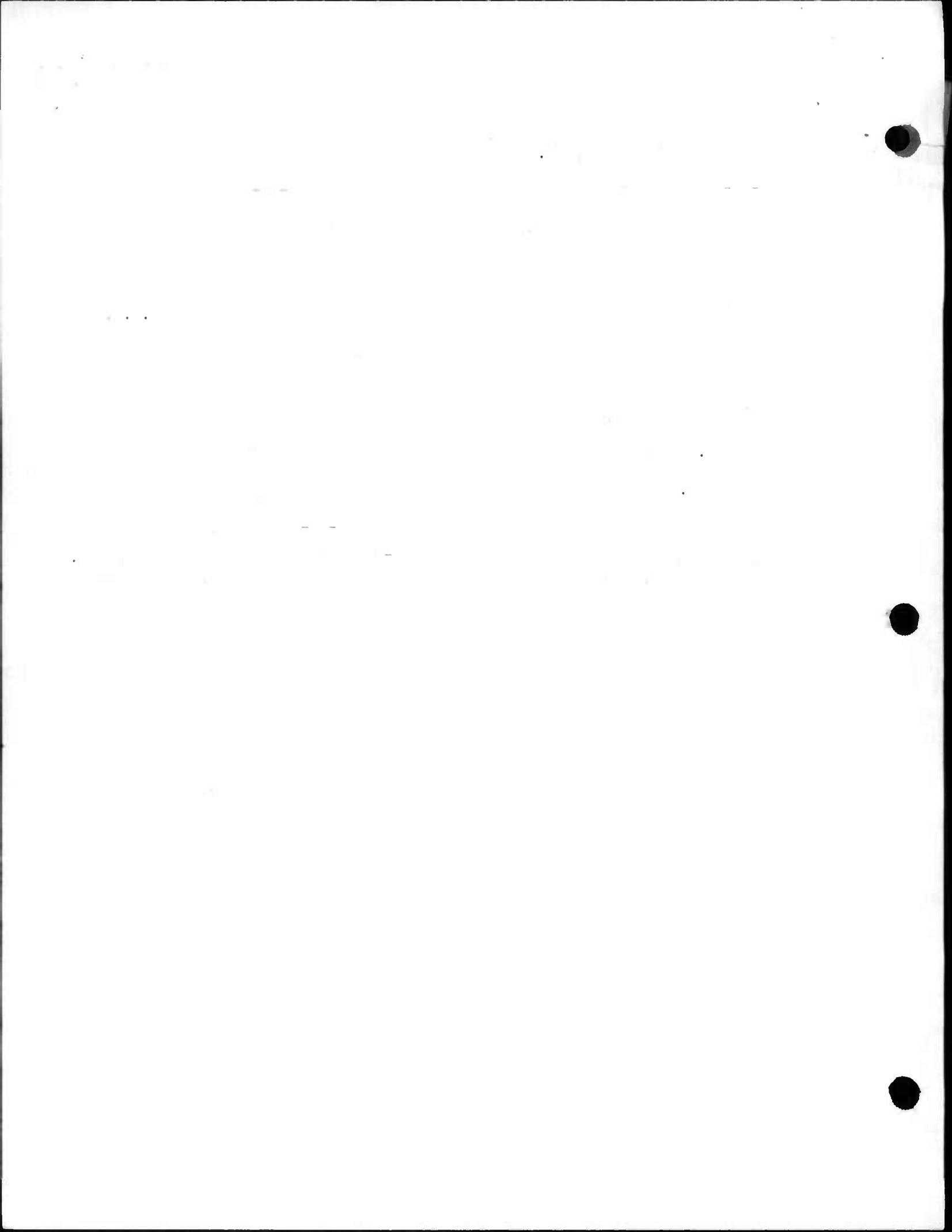
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ESSIE MAE PROFIT | | | | 2. DATE OF DEATH MONTH DAY YEAR 05 15 1990 | | 3. TIME OF DEATH 8:58 A M | |
| 4. SOCIAL SECURITY NUMBER 267-30-7919 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12/29/21 | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE CITY | |
| 10a. STATE MD | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE, CITY | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2816 OVERLAND AVE. | | | |
| 10f. ZIP CODE 21214 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6th GRADE | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEKEEPING | | 16b. KIND OF BUSINESS/INDUSTRY ST. JOSEPH HOSP. | | | |
| 17. FATHER'S NAME (First, Middle, Last) BAKER DARRON SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MATILDA BOATWRIGHT | | | |
| 19a. INFORMANT'S NAME (Type/Print) LILLIE BURGESS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2816 OVERLAND AVE. BALTO. MD. 21214 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin L. Williams</i> | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CEREBROVASCULAR ACCIDENT</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>PNEUMONIA</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>DIABETES MELLITUS</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>CHRONIC RENAL INSUFFICIENCY</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HYPERTENSION</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>David M. Cromwell</i> MEDICAL INTERN | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID M. CROMWELL MD 600 N. WOLFE ST. BALTIMORE, MD 21205 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson</i> | | | |

Handwritten text at the bottom of the page, possibly a signature or date, including the word "March".

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) GEORGE FRANKLIN PARKS | | | | 2. DATE OF DEATH MAY 17 1990 | | 3. TIME OF DEATH 6:35 a.m. M | |
| 4. SOCIAL SECURITY NUMBER 220-05-7960 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 25, 1909 | |
| 8. BIRTHPLACE (State or Foreign Country) Pa. | | | | 9. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 10. COUNTY OF DEATH BALTIMORE CITY | |
| 11. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | | | | |
| 12. RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 318 Holy Cross Road | | | | 10f. ZIP CODE 21225 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Peacetime | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: X | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Transportation | | 16b. KIND OF BUSINESS/INDUSTRY Martin Marietta Corp. | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Parks | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mable Schultz | | | |
| 19a. INFORMANT'S NAME (Type/Print) Kenneth F. Parks | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 Holy Cross Rd. Baltimore, Md. 21225 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. May 21, 1990 | | 20c. LOCATION — City or Town, State Timonium, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Gladden | | | | 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Inc. 5305 Harford Rd. 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. <u>Cardiac Arrest</u> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. <u>Cardiac Ischemia</u> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. <u>Critical stenoses in coronary arteries</u> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. _____ | | | | | | | |
| Approximate Interval Between Onset and Death 20 min 6 days 11 years. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) | | | | | |
| HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER James D. Quinn M.D. Resident | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) May 17 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NANNING, James J. Johns Hopkins Hospital Baltimore Md | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13469

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) SYLVIA PHILLIPS Sylvia Figinski Philips | | | | 2. DATE OF DEATH MONTH DAY YEAR 5-15-90 | | 3. TIME OF DEATH 2:40 PM | |
| 4. SOCIAL SECURITY NUMBER 214-14-2155 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-12-16 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) FRancis Scott Key MEDical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, Md. | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MD. | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 200 South Clinton Street | |
| 10f. ZIP CODE 21224 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Hotel Work | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Raymond Figinski | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) HElen | | | |
| 19a. INFORMANT'S NAME (Type/Print) Hilary Figinski | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7306 Fait avenue Baltimore, Maryland-21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kathleen M. Murphy | | | | 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. Baltimore, Md.-21206 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Cirrhosis DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Lymphoma DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition Rectovaginal Fistula | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ann Fitzgerald MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann Fitzgerald MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE John C. Miller | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30407

90 13470

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Bernard McKinley Paylor | | | | 2. DATE OF DEATH MONTH 5 DAY 15 YEAR 1990 | | 3. TIME OF DEATH 6:40 p.m. | |
| 4. SOCIAL SECURITY NUMBER 218-60-6660 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 36 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-28-53 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH none | | | | 10a. STATE Maryland | | 10b. COUNTY none | |
| 10c. CITY, TOWN OR LOCATION Baltimore City | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1302 E. Lafayette Avenue | |
| 10f. ZIP CODE 21213 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Negroid | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) none | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk | | 16b. KIND OF BUSINESS/INDUSTRY Industry and Government | |
| 17. FATHER'S NAME (First, Middle, Last) William Paylor | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bernice Harrison | | | |
| 19a. INFORMANT'S NAME (Type/Print) William and Bernice Paylor | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2137 Homewood Ave. Baltimore, Md. 21218 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland National Memorial Pk/ Laurel, Maryland | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs</i> | | | | 22. NAME AND ADDRESS OF FACILITY Calvin B. Scruggs Funeral Home 1412 E. Preston Street, Balto, Md. 21218 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure + ARDS b. Infection (Infection) c. AIDS (AIDS) d. - Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure (Renal failure) | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) NA | | 28b. TIME OF INJURY NA M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED NA | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NA | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Harake MD</i> | | | | 29c. LICENSE NUMBER D 39663 | | 29d. DATE SIGNED (Month, Day, Year) 5/15/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mages EL-Harake MD, The Union Memorial Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John L. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

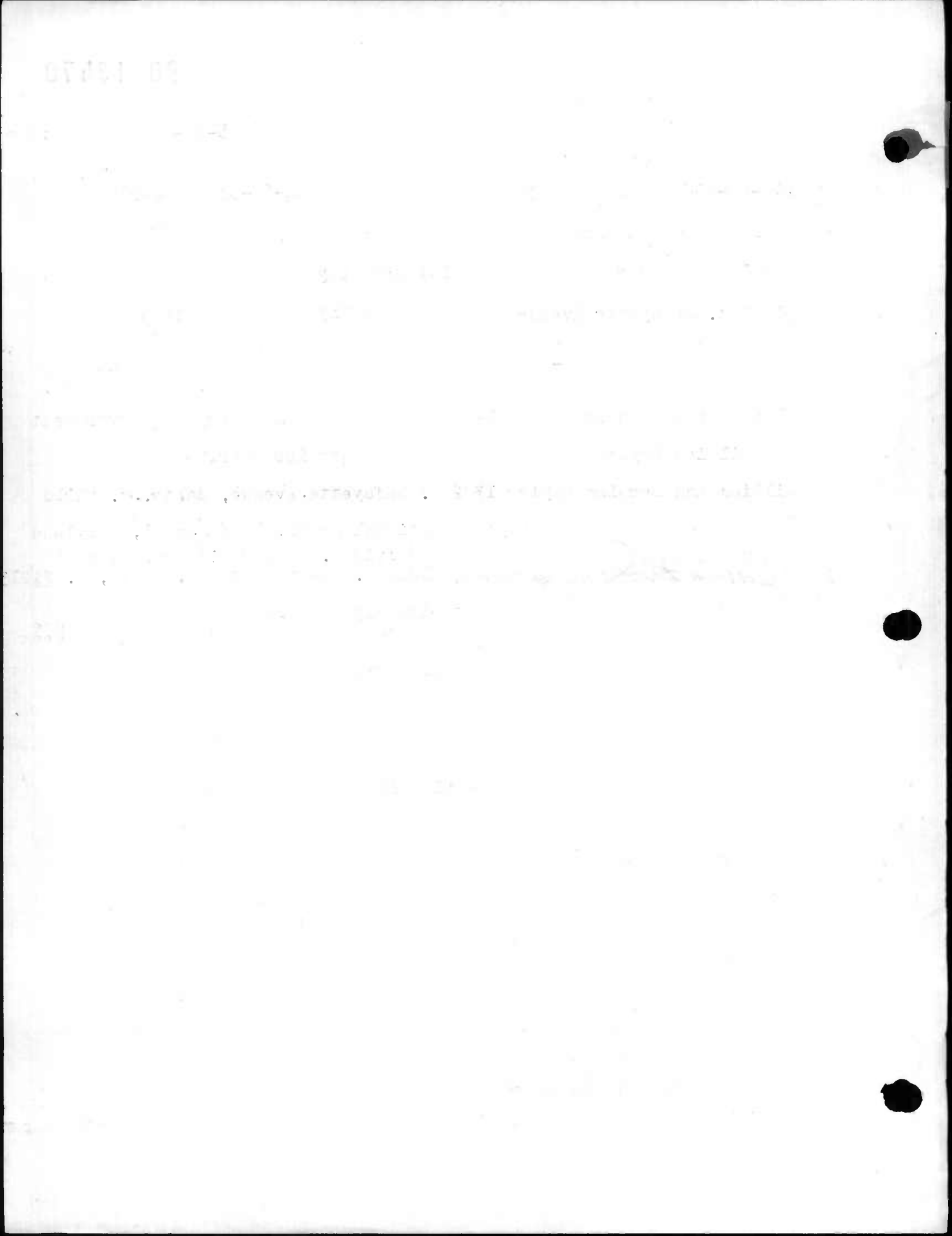
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) NINA Y. ROBINSON | | | | 2. DATE OF DEATH MONTH 5 DAY 11 YEAR 90 | | 3. TIME OF DEATH 8:29 P M | |
| 4. SOCIAL SECURITY NUMBER 220-86-2838 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 26 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2-11-64 | |
| 8. BIRTHPLACE (State or Foreign Country) Balto. Md | | | | 9a. FACILITY NAME (If not institution, give street and number) 422 N. Chester Street | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE Maryland | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 422 N. Chester St | |
| 10f. ZIP CODE 21231 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Earl Vido | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Andrew Lucas | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Robinson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Annie Robinson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 422 N. Chester St Balto. Md. 21231 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Cem. | | 20c. LOCATION — City or Town, State Balto. Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph J. Russ | | | | 22. NAME AND ADDRESS OF FACILITY Joseph A. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Contact Gunshot Wound of Head DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Head Only |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) 5-11-90 | | | | 28b. TIME OF INJURY 8:25 PM | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED Subject shot self | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) home | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 422 N. Chester St. Baltimore City, Maryland | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ann M. Dixon, M.D., Deputy Chief | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) 5-12-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann M. Dixon, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 vl | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE John H. H. H. | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

17/11/11

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) ROSA LEE ROLLINS | | | | | | 2. DATE OF DEATH MONTH 5 DAY 14 YEAR 1990 | | 3. TIME OF DEATH 1730 M | |
| 4. SOCIAL SECURITY NUMBER 219-28-2254 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11/28/33 | | 8. BIRTHPLACE (State or Foreign Country) SO. CAROLINA | |
| 9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSP. | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, MD. | | 9c. COUNTY OF DEATH USA | |
| 10a. STATE MD. | | | | | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | 10e. STREET AND NUMBER 2700 REESE ST. 1ST. FLOOR | | 10f. ZIP CODE 21218 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th GRADE College (1-4 or 5+) UNEMPLOYED | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED | | | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES CAROLINE | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) QUEEN ESTHER JOHNSON | | | |
| 19a. INFORMANT'S NAME (Type/Print) GERTRUDE CAROLINE | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 724 EXETER HALL BALTO, MD. 21218 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vanessa Coal | | | | | | 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of liver DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death 9 months | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus, insulin dependent | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Extended Care Unit of Union Memorial Hospital | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28h. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER W.B. Daniels, Jr. MD | |
| 29c. LICENSE NUMBER 202225 | | | | | | | | 29d. DATE SIGNED (Month, Day, Year) 5/14/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W.B. Daniels, Jr. Union Memorial Hospice, Balto 21218 | | | | | | | | 31. DATE FILED (Month, Day, Year) MAY 18 1990 | |
| 32. REGISTRAR'S SIGNATURE John R. ... | | | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|---|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) <i>Helen May Smith</i> | | | | 2. DATE OF DEATH MONTH <i>5</i> DAY <i>15</i> YEAR <i>90</i> | | | | 3. TIME OF DEATH <i>6:30 AM</i> | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>NONE</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>90</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>05/05/1900</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Forest Haven Nursing Home</i> | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Catonsville</i> | | | 9c. COUNTY OF DEATH <i>Baltimore</i> | | | | |
| 10a. STATE <i>Maryland</i> | | | | 10b. COUNTY <i>N/A</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore City (Brooklyn)</i> | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER <i>826 E. Jeffrey Street</i> | | | | | | 10f. ZIP CODE <i>21225</i> | | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>None</i> College (1-4 or 5+) <i></i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY <i>Housewife</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>William Sabins</i> | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Anna Sabins</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Mr. Earl H. Smith, Jr</i> | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3334 North Chatham Road, Ellicott City, Md. 21043</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Glen Haven Memorial Park</i> | | | | 20c. LOCATION — City or Town, State <i>Glen Burnie, Maryland</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kevin E. Ecker</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY <i>McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) <i>N/A</i> | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Harold B. Bob</i> | | | | 29c. LICENSE NUMBER <i>D15872</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>5/15/90</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>HAROLD B. BOB 7220 Park Height 21206</i> | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>MAY 18 1990</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Howard T. Saylor | | | | 2. DATE OF DEATH MONTH 5 DAY 16 YEAR 90 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 212-18-4307 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-14-16 | |
| 8. BIRTHPLACE (State or Foreign Country) Balto. Md. | | 9a. FACILITY NAME (If not institution, give street and number) Manor Care Nursing Home - Rossville | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Rossville | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6600 Ridge Road | | | | 10f. ZIP CODE 21237 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assembly Work | | 16b. KIND OF BUSINESS/INDUSTRY Schaffer Brewery | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles J. Saylor Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Murphy | | | |
| 19a. INFORMANT'S NAME (Type/Print) Myrtle R. Crandell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4507 Raspe Avenue Baltimore, Md.-21206 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen M. Murphy</i> | | | | 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 BELAIR Road Baltimore, Md.-21206 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Adenocarcinoma of the lung</i> Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>with metastasis to the brain.</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>COPD and emphysema</i> <i>ASCVD advanced</i> <i>arterial hypertension</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael A. Hyle</i> | | | | 29c. LICENSE NUMBER D27693 | | 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL A. Hyle M.D. 7527 BELAIR Rd 21236 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MICHAEL J. SULLIVAN | | | | 2. DATE OF DEATH MONTH 5 DAY 16 YEAR 90 | | 3. TIME OF DEATH 8:15P M | |
| 4. SOCIAL SECURITY NUMBER 214-03-1259 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8/3/09 | |
| 8a. FACILITY NAME (If not institution, give street and number) DEATON MEDICAL CENTER | | | | 8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 8c. COUNTY OF DEATH -- | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY HOWARD | | 10c. CITY, TOWN OR LOCATION COLUMBIA | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 7080 CRADLEROCK WAY | | | |
| 10f. ZIP CODE 21045 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALESMAN | | 16b. KIND OF BUSINESS/INDUSTRY INSURANCE | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH H. SULLIVAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) AMALIA SCHALITZKY | | | |
| 19a. INFORMANT'S NAME (Type/Print) HELEN SULLIVAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7080 CRADLEROCK WAY, COLUMBIA, MD. 21045 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) PROSPECT HILL CEMETERY | | 20c. LOCATION — City or Town, State TOWSON, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): 2 wks | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Tracheostomy | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): 8 months | | | | | | | |
| Subdural hematoma | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): 9 months | | | | | | | |
| fall | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): 9 months | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic heart failure, pleural effusions, hypertension s/p evacuation of subdural hematoma x2 | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 9/2/89 | |
| 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED fall | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) Howard County | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Timothy J. Keane | | | | 29c. LICENSE NUMBER D37458 | | 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DEATON MEDICAL CENTER, BALTIMORE, MARYLAND | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13476

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) MARGARET VIRGINIA TILLMAN | | | | 2. DATE OF DEATH MONTH 5 DAY 16 YEAR 90 | | 3. TIME OF DEATH 10:15P.M. M | |
| 4. SOCIAL SECURITY NUMBER 215-18-7280 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 5. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8/11/03 | |
| 9a. FACILITY NAME (If not institution, give street and number) Summit Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Catonsville | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1940 McHenry Street | | | | 10f. ZIP CODE 21223 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chocolate Dipper | | 16b. KIND OF BUSINESS/INDUSTRY Candy Maker | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edward Blankner | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Boettinger | | | |
| 19a. INFORMANT'S NAME (Type/Print) Donald E. Tillman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2105 N. Rolling Road Baltimore, MD 21228 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M. Neal Coleman | | | | 22. NAME AND ADDRESS OF FACILITY Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): c. Alzheimer's Disease DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 1 wk 1 wk 2 yrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
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| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 | | | |

277-100-1000

REG. NO.

OHMH-16 Rev 1/89

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Willie Washington | | | | 2. DATE OF DEATH MONTH DAY YEAR May 10, 1990 | | 3. TIME OF DEATH 4:00 P M | |
| 4. SOCIAL SECURITY NUMBER 212-60-9096 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 36 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 8-11-53 | | 8. BIRTHPLACE (State or Foreign Country) S.C. | |
| 9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore City | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1303 Madison Ave Apt E | | | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unemployed | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Robert Washington | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Scarborough | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Louise Washington | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1303 Madison Ave. Apt E, Balto. Md. 21217 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cem. | | 20c. LOCATION — City or Town, State Balto. Co. Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph J. Russ | | | | 22. NAME AND ADDRESS OF FACILITY Joseph J. Russ FUNERAL HOME 2222 W. North Ave. Balto. Md. 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypotension DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Pancreatic Pseudocyst DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ching Wong, M.D. | | | | 29c. LICENSE NUMBER N/A | | 29d. DATE SIGNED (Month, Day, Year) 5/11/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ching Wong, M.D. c/o Maryland General Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Lucille Elizabeth WOODY | | | | 2. DATE OF DEATH MONTH DAY YEAR May 17, 1990 | | 3. TIME OF DEATH 4:30 A M | |
| 4. SOCIAL SECURITY NUMBER 212-05-5148 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-22-11 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Essex | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Middle River | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 47 Beech Drive, Apt. B1 | |
| 10f. ZIP CODE 21220 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | | | 16b. KIND OF BUSINESS/INDUSTRY Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Crothers | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Horn | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Joanne Woody | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47 Beech Drive, Apt. B1 Baltimore, MD 21220 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olivet Cemetery | | 20c. LOCATION — City or Town, State Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Cardiopulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Hagan</i> | | | | 29c. LICENSE NUMBER D37242 | | 29d. DATE SIGNED (Month, Day, Year) 5/17/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Hagan, M.D. 9000 Franklin Sq. Dr., Balto., 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 18 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>J. Davidson Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2011-12-15

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM F. WENDLER | | | | 2. DATE OF DEATH MONTH DAY YEAR May 17, 1990 | | 3. TIME OF DEATH 0120 a m | |
| 4. SOCIAL SECURITY NUMBER 218 03 8185 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7/25/12 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE Maryland | | 10b. COUNTY Balto. City | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1405 Forge Avenue | |
| 10f. ZIP CODE 21209 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Letter Carrier | | 16b. KIND OF BUSINESS/INDUSTRY Post Office | |
| 17. FATHER'S NAME (First, Middle, Last) Paul Alvin Wendler | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes May Yingling | | | |
| 19a. INFORMANT'S NAME (Type/Print) Alice C. Herschberger | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1405 Forge Avenue Baltimore, Maryland 21209 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery | | 20c. LOCATION — City or Town, State Garrison Forest, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE B. Henss | | | | 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road, Baltimore, Maryland 21211 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MALIGNANT LYMPHOMA AND PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE LUNG DISEASE | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Charles C. Brown, M.D. - Pathologist | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) MAY 17, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES C. BROWN, M.D. 201 E. UNIV. PARKWAY - 21218 | | | | | | | |
| 31. DATE OF DEATH MAY 16 1990 | | | | 32. REGISTRAR'S SIGNATURE J. Henss | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 of this certificate is to be attached to the hospital or attending physician's report and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

90 13481

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Eleanor S. Anderson | | | | 2. DATE OF DEATH MONTH 4 DAY 30 YEAR 90 | | 3. TIME OF DEATH 3:10 A M | | | |
| 4. SOCIAL SECURITY NUMBER 218-01-7387 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7-8-05 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Calvert Manor Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rising Sun | | | | 9c. COUNTY OF DEATH Cecil | |
| 10a. STATE Maryland | | 10b. COUNTY Cecil | | 10c. CITY, TOWN OR LOCATION Perryville | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER P.O. Box 43 | | | | 10f. ZIP CODE 21903 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) ---- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) House wife | | 16b. KIND OF BUSINESS/INDUSTRY ----- | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Robert Shoupek | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Shannon | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Samuel R. Anderson Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 759 Aiken Ave. Perryville Md. 21903 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) West Nottingham Cemetery | | 20c. LOCATION — City or Town, State Colora, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert J. Patterson, Sr. | | | | 22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Heart Failure Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Hypertensive Atherosclerosis a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death 1 Day 10 yrs | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dudley Phillips MD | | | | 29c. LICENSE NUMBER D 09482 | | 29d. DATE SIGNED (Month, Day, Year) 4/30/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dudley Phillips MD 2017 Trappe Church Rd. Poolesville, Md 21034 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 2 '90 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

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90 13482

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Khavar Assurian | | | | 2. DATE OF DEATH MONTH DAY YEAR 4 27 90 | | 3. TIME OF DEATH 1:00 A M | |
| 4. SOCIAL SECURITY NUMBER 218 88 5886 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (last birthday) 91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-1-1899 | |
| 8. BIRTHPLACE (State or Foreign Country) Iran | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Medlantic Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Silver Spring | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2005 Treetop Lane #14 | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? Permanent resident | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify Iranian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) None College (13 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired). Housewife | | 16b. KIND OF BUSINESS/INDUSTRY own home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Nison (unknown) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Gorgy (unknown) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Emanuel Assurian | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Gruenther Ave., Rockville, Md. 20851 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | 20c. LOCATION — City or Town, State Silver Spring, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael J. Dinala | | | | 22. NAME AND ADDRESS OF FACILITY Hines/Rinaldi Funeral Home 11800 N.H. Ave., S.S. Md. 20904 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral Vascular Accident DUE TO (OR AS A CONSEQUENCE OF): PARKINSON DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. M. Maloreno | | | | 29c. LICENSE NUMBER DB5362 | | 29d. DATE SIGNED (Month, Day, Year) 4/27/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 12102 Georgia Ave., Silver Spring, Md. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 30 '90 | | | | 32. REGISTRAR'S SIGNATURE J. Davidson Handell | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Wayne Armiger

90 13483

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Wayne H. Armiger</u> | | | | 2. DATE OF DEATH MONTH <u>4</u> - DAY <u>22</u> - YEAR <u>90</u> | | 3. TIME OF DEATH <u>5:30</u> P.M. | | | |
| 4. SOCIAL SECURITY NUMBER <u>219-48-1555</u> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>44</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>5-10-1945</u> | | 8. BIRTHPLACE (State or Foreign Country) <u>Washington D.C.</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Laurel/Beltsville Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Laurel</u> | | | 9c. COUNTY OF DEATH <u>Prince George</u> | | |
| 10a. STATE <u>Maryland</u> | | 10b. COUNTY <u>Prince George</u> | | 10c. CITY, TOWN OR LOCATION <u>Beltsville</u> | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER <u>11030 Montgomery Road</u> | | | | 10f. ZIP CODE <u>20705</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>United States</u> | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u> <u>11 years</u> | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Never Worked</u> | | 16. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Walter H. Armiger</u> | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Gladys V. Johns</u> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Gladys V. Armiger</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>same as # 10</u> | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Fort Lincoln Cemetery</u> | | 20c. LOCATION — City or Town, State <u>Brentwood, Maryland</u> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Donald V. Borgwardt</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Borgwardt Funeral Home</u> <u>4400 Powder Mill Rd. Beltsville, Md. 20705</u> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>pulmonary edema, respiratory failure</u> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <u>renal failure</u> c. <u>diabetes mellitus</u> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Martin D. Weitz</u> | | 29c. LICENSE NUMBER <u>D23143</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>4-22-90</u> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>MARTIN WEITZ 7525 Greenway Ct Greenbelt Maryland 20770</u> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>APR 26 '90</u> | | 32. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Addis V. Augustine | | | | 2. DATE OF DEATH 05-01-90 | | 3. TIME OF DEATH 9:30 A.M. | |
| SOCIAL SECURITY NUMBER 216-22-1189 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. & birthday) 62 YRS. | | 7. DATE OF BIRTH 07-05-27 | |
| 8. BIRTHPLACE (State or Foreign Country) North Carolina | | 9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Annapolis | | 9c. COUNTY OF DEATH Anne Arundel | |
| 10a. STATE MD | | | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Lothian | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 6340 Mallard Lane | | | |
| 10f. ZIP CODE 20711 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Household | | | |
| 17. FATHER'S NAME (First, Middle, Last) Leon R. Faircloth | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alma Capps | | | |
| 19a. INFORMANT'S NAME (Type/Print) Timothy G. Augustine | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6340 Mallard Lane, Lothian, MD 20711 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lakemont Cemetery | | 20c. LOCATION — City or Town, State Davidsonville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home P.A. 12 Ridgely Ave. Annapolis, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>[Handwritten: Acute gastrointestinal hemorrhage]</i> b. <i>[Handwritten: myocardial infarction (CA)]</i> c. <i>[Handwritten:]</i> d. <i>[Handwritten:]</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 1 wk unlabeled |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D. | | | | 29c. LICENSE NUMBER D311 88 | | 29d. DATE SIGNED (Month, Day, Year) 5/1/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 Ridgely Ave. Annapolis MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 2 1990 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transmission form. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13485

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) John Ambrose Hamilton | | 2. DATE OF DEATH 5 4 90 | | 3. TIME OF DEATH 5:30 A. | |
| 4. SOCIAL SECURITY NUMBER 219-36-4230 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) May 1, 1923 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 11223 Creagersstown Road | | 9b. CITY, TOWN OR LOCATION OF DEATH Woodsboro | | 9c. COUNTY OF DEATH Frederick | |
| 10a. STATE Maryland | | 10b. COUNTY Frederick | | 10c. CITY, TOWN OR LOCATION Woodsboro | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 11223 Creagersstown Road | | 10f. ZIP CODE 21798 | |
| 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer | | 16b. KIND OF BUSINESS/INDUSTRY Farming | |
| 17. FATHER'S NAME (First, Middle, Last) John H. Ambrose, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Eyler | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ruby D. Ambrose | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11223 Creagersstown Road, Woodsboro, Md. 21798 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Hill Cemetery | | 20c. LOCATION — City or Town, State Woodsboro, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Sharon Camille Cline | | 22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home 1621 Upossuntown Pike, Frederick, Md. 21701 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Diabetes mellitus | | | | | Approximate Interval Between Onset and Death 3 yrs years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Casper E. Chittum MD | | 29c. LICENSE NUMBER D16428 | |
| 29d. DATE SIGNED (Month, Day, Year) 5/4/90 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | |
| 31. DATE FILED (Month, Day, Year) MAY 07 1990 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DO NOT

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Constance Mary Baldwin | | | | | | 2. DATE OF DEATH MONTH 5 DAY 1 YEAR 90 | | 3. TIME OF DEATH 2239 M | |
| 4. SOCIAL SECURITY NUMBER 116-03-1261 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 31, 1916 | | 8. BIRTHPLACE (State or Foreign Country) New York | |
| 9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown | | 9c. COUNTY OF DEATH Washington | |
| 10a. STATE Maryland | | 10b. COUNTY Washington | | 10c. CITY, TOWN OR LOCATION Hagerstown | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 7 E. Washington Street | | | | | | 10f. ZIP CODE 21740 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) — — — College (1-4 or 5+) — — — | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Nicholas Citarelli | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Barcia | | | |
| 19a. INFORMANT'S NAME (Type/Print) Martha Dante | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2407 Weber Way, Hagerstown, Maryland 21740 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Patrick's Cemetery | | 20c. LOCATION — City or Town, State Bay Shore, N.Y. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott Minnick | | | | | | 22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION WITH EXTENSION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death 2 WEEKS YEARS | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE NON-SUSTAINED VENTRICULAR TACHYCARDIA RENAL FAILURE HYPERTENSION | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Paul Fox Bradford, M.D. | | | | | | 29c. LICENSE NUMBER A38892 | | 29d. DATE SIGNED (Month, Day, Year) 5/2/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANITA FOX BRADFORD, M.D. 1879 HOWELL RD. HAGERSTOWN, MD 21740 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 03 '90 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 of this certificate is to be attached to the hospital or attending physician's report. Page 6 of this certificate is to be attached to the hospital or attending physician's report. Page 6 of this certificate is to be attached to the hospital or attending physician's report.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Laurie Jean Bast | | | | 2. DATE OF DEATH MONTH DAY YEAR 5 2 1990 | | 3. TIME OF DEATH 8:15 A M | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 89 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 1-3-1901 | | 8. BIRTHPLACE (State or Foreign Country) Frederick Co., Md. | |
| 9a. FACILITY NAME (If not institution, give street and number) Reeders Memorial Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Boonsboro | | 9c. COUNTY OF DEATH Washington | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Frederick | | 10c. CITY, TOWN OR LOCATION Braddock Heights | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE 21714 | | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | | 16b. KIND OF BUSINESS/INDUSTRY Public Schools | |
| 17. FATHER'S NAME (First, Middle, Last) David G. White | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Martin | | | |
| 19a. INFORMANT'S NAME (Type/Print) David W. Ament | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Braddock Heights, Md. 21714 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Boonsboro Mausoleum | | 20c. LOCATION — City or Town, State Boonsboro, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE John H. Bast, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY BAST FUNERAL HOME, 7606 Boonsboro Pike, Boonsboro, Md. 21713 | | | |
| 23. PART I. Enter the diseases, or complications they caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. probable cerebro-vascular accident DUE TO (OR AS A CONSEQUENCE OF): b. generalized atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 5-2-90 | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER R. Guedenet | | | | 29c. LICENSE NUMBER D32518 | | 29d. DATE SIGNED (Month, Day, Year) 5-2-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Guedenet, M. D. 100 Geeting Lane, Keedysville, Md. 21756 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 07 '90 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be used for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

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REG NO

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it must be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be called at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | 90 13489 | | |
|---|--|---|---|---|---|--|--|---|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CAROLINE R. BERG | | | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 1, 1990 | | 3. TIME OF DEATH 10:10 A M | | | | |
| 4. SOCIAL SECURITY NUMBER 577-07-3210 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MAY 18, 1895 | | 8. BIRTHPLACE (State or Foreign Country) WASHINGTON, D.C. | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY CONV. NURSING HOME | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH WHEATON | | 9c. COUNTY OF DEATH MONTGOMERY | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY MONTGOMERY | | 10c. CITY, TOWN OR LOCATION ROCKVILLE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | |
| 10e. STREET AND NUMBER 10108 BURTON GLEN DRIVE | | | | | | 10f. ZIP CODE 20850 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALESPERSON | | 16b. KIND OF BUSINESS/INDUSTRY KANNS DEPT. STORE | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) DOUGLAS BICKERTON | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LANDONIA SCROGGINS | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) RITA L. HUGHES | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10108 BURTON GLEN DRIVE ROCKVILLE, MARYLAND 20850 | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) PROSPECT HILL CEMETERY | | 20c. LOCATION — City or Town, State WASHINGTON, D.C. | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | | | 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL SPR., MD. 20901 | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest | | | | | | | | | | immed | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | 10 yrs | | |
| arteriosclerotic heart disease | | | | | | | | | | 20 yrs | | |
| generalized arteriosclerosis | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. osteoarthritis/osteoporosis | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | | | 29c. LICENSE NUMBER D13156 | | 29d. DATE SIGNED (Month, Day, Year) 2 May 90 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John M. Wyman, M.D. 7801 Norfolk Avenue Bethesda, Maryland 20814 | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 03 '90 | | 32. REGISTRAR'S SIGNATURE  | | | | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Orman R. Barkdoll, Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR May 3, 1990 | | 3. TIME OF DEATH 9:00 AM | |
| 4. SOCIAL SECURITY NUMBER 338-28-9219 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 21, 1931 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) 2288 Glenmore Terrace | | 9b. CITY, TOWN OR LOCATION OF DEATH Rockville | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Rockville | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 2288 Glenmore Terrace | |
| 10f. ZIP CODE 20850 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korea | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Programmer | | 18b. KIND OF BUSINESS/INDUSTRY General Electric | |
| 17. FATHER'S NAME (First, Middle, Last) Orman R. Barkdoll | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucille Young | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary J. Barkdoll | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2288 Glenmore Terrace, Rockville, Maryland 20850 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | 20c. LOCATION — City or Town, State Silver Spring, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00381 Barbara Jo McMullen Lawrence | | | | 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): acute myocardial infarction | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John F. Tauber, M.D. | | | | 29c. LICENSE NUMBER D08546 | | 29d. DATE SIGNED (Month, Day, Year) May 3, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John F. Tauber, M.D. 8218 Wisconsin Avenue, Bethesda, Maryland 20814 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 07 '90 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>ANN G. BALCOM</u> | | | | 2. DATE OF DEATH MONTH DAY YEAR <u>April 30, 1990</u> | | 3. TIME OF DEATH M <u>7pm</u> | |
| 4. SOCIAL SECURITY NUMBER <u>577-18-9710</u> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>87</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>Oct. 10, 1902</u> | |
| 8. BIRTHPLACE (State or Foreign Country) <u>Miss.</u> | | | | 9a. CITY, TOWN OR LOCATION OF DEATH <u>LANHAM SEABROOK</u> | | 9c. COUNTY OF DEATH <u>PRINCE GEORGE'S</u> | |
| 9b. FACILITY NAME (If not institution, give street and number) <u>AMI DOCTORS' HOSPITAL of P.G.Co.</u> | | | | RESIDENCE OF DECEDENT | | | |
| 10a. STATE <u>MD</u> | | 10b. COUNTY <u>Prince George's</u> | | 10c. CITY, TOWN OR LOCATION <u>Largo</u> | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <u>600 Largo Road</u> | | | | 10f. ZIP CODE <u>20772</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>College</u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Secretary</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>U.S. Gov't.</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Walter Boyd</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Annie Grace</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>William Harvey</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>P.O. Box 96202, Washington, D.C. 20090</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Rose Hill-Magnolia Cemetery</u> | | 20c. LOCATION — City or Town, State <u>Meridian, Miss.</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Michael S. Nelson</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisconsin Ave. NW, Washington, D.C. 20016</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Coronary Heart Failure</u> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>Acute Heart Failure</u> b. <u>Septicemia</u> c. <u>Septicemia</u> d. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes, mellitus, type II</u> <u>Hypertension</u> <u>Dehydration</u> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <u>1</u> <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>M.D.</u> | | | | 29c. LICENSE NUMBER <u>732261</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>5-1-90</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Richard J. Feldman, MD 9500 Annapolis Rd, Carhan, MD 20706</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>MAY 04 '90</u> | | | | 32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Harold Clarence Baker</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>May 5 1990</i> | | 3. TIME OF DEATH M <i>11:30</i> | |
| 4. SOCIAL SECURITY NUMBER 313 30 4515 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 3, 1926 | |
| 8. BIRTHPLACE (State or Foreign Country) Indiana | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Mont. General Hosp</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Olney</i> | | 9c. COUNTY OF DEATH <i>MD</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Rockville | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 13707 Arctic Avenue | | | | 10f. ZIP CODE 20853 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Dept. of the Navy | | | |
| 17. FATHER'S NAME (First, Middle, Last) Clarence V. Baker | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Smith | | | |
| 19a. INFORMANT'S NAME (Type/Print) Retha F. Baker | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13707 Arctic Ave., Rockville, Maryland 20853 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Park | | 20c. LOCATION — City or Town, State Rockville, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Douglas C. Dial</i> M00522 | | | | 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial Dis</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Carcinoma of lung - metastatic</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> N/A OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John S. Rogers, M.D.</i> | | | | 29c. LICENSE NUMBER D09975 | | 29d. DATE SIGNED (Month, Day, Year) May 6, 1990 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John S. Rogers, M.D., 1919 Seminary Road, Silver Spring, Maryland 20910 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 07 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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SEP 1

Handwritten text, possibly a signature or date, located in the center of the page.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Austin M. Broadnax | | | | 2. DATE OF DEATH MONTH 5 DAY 4 YEAR 90 | | 3. TIME OF DEATH 08:13 AM | |
| 4. SOCIAL SECURITY NUMBER 579-09-3514 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-29-1923 | |
| 8. BIRTHPLACE (State or Foreign Country) Wash. D.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE D.C. | | 10b. COUNTY NONE | |
| 10c. CITY, TOWN OR LOCATION Washington D.C. | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 4702 6th., Pl., N.E. | |
| 10f. ZIP CODE 20017 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) ----- College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager | | 16b. KIND OF BUSINESS/INDUSTRY Residential Property | |
| 17. FATHER'S NAME (First, Middle, Last) Auston - Broadnax | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie - Milliner | | | |
| 19a. INFORMANT'S NAME (Type/Print) Norma M. Broadnax | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4702 6th., Pl., N.E., Washington D.C. 20017 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Chambers Crematory | | 20c. LOCATION — City or Town, State Riverdale, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas S. Chambers | | | | 22. NAME AND ADDRESS OF FACILITY W.W. Chambers Co. Inc. 5801 Cleveland Ave. Riverdale, MD. 20737 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARCINOMATOSIS a. DUE TO (OR AS A CONSEQUENCE OF): b. METASTATIC ADENOCARCINOMA Unknown Primary c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Arthur K | | | | 29c. LICENSE NUMBER D27865 | | 29d. DATE SIGNED (Month, Day, Year) 5/4/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARK LI 1721 University Blvd W. Wheaton MD 20902 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 07 '90 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Douglas Neville Bonifant | | | | 2. DATE OF DEATH MONTH DAY YEAR May 6 90 | | 3. TIME OF DEATH 3:19 AM | |
| 4. SOCIAL SECURITY NUMBER 212-62-4913 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 38 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2/23/52 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE MD | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 13244 Old Columbia Pike | |
| 10f. ZIP CODE 20904 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) - | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled Security Manager | | 16b. KIND OF BUSINESS/INDUSTRY Security | |
| 17. FATHER'S NAME (First, Middle, Last) John L. Bonifant | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret O'Connor | | | |
| 19a. INFORMANT'S NAME (Type/Print) Toni A. Bonifant | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13244 Old Columbia Pike - Sil. Spg., Md. 20904 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) George Washington Cemetery | | 20c. LOCATION — City or Town, State Adelphi, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William T. Conrad</i> | | | | 22. NAME AND ADDRESS OF FACILITY Takoma Funeral Home 254 Carroll St., N.W. Wash., D.C. 20012 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. VENTRICULAR TACHYCARDIA | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. ARTERIOSCLEROTIC CARDIAC DISEASE | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DIABETES MELLITUS | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. 30 min | | | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| RENAL FAILURE - CHRONIC | | | | | | | |
| GANGRENE OF FOOT | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Garry D. Ruben</i> MD | | | | 29c. LICENSE NUMBER 21153 | | 29d. DATE SIGNED (Month, Day, Year) 5-6-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GARRY D. RUBEN, MD 11120 New Hampshire Ave, SILVER SPRING, MD 20904 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 07 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Margaret P. Bounds | | | | 2. DATE OF DEATH MONTH 05 DAY 01 YEAR 90 | | 3. TIME OF DEATH 0315 M | |
| 4. SOCIAL SECURITY NUMBER 215-26-2563 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05-20-27 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 706 S. Kaywood Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH Salisbury | |
| 9c. COUNTY OF DEATH Wicomico | | | | 10a. STATE MD | | 10b. COUNTY Wicomico | |
| 10c. CITY, TOWN OR LOCATION Salisbury | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 706 S. Kaywood Dr. | |
| 10f. ZIP CODE 21801 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | 16b. KIND OF BUSINESS/INDUSTRY Used Car Co. | |
| 17. FATHER'S NAME (First, Middle, Last) Luther E. Payne | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Griffith | | | |
| 19a. INFORMANT'S NAME (Type/Print) Stephen Bounds | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 S. Kaywood Dr. Salisbury, Maryland | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Parsons cemetery | | 20c. LOCATION — City or Town, State Salisbury, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald E. Bounds</i> | | | | 22. NAME AND ADDRESS OF FACILITY Bounds Funeral Home Salisbury, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Mitral Insufficiency DUE TO (OR AS A CONSEQUENCE OF): c. Aortic Stenosis and Insufficiency DUE TO (OR AS A CONSEQUENCE OF): d. Rheumatic Heart Disease, inactive Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John T. Bulkeley</i> | | | | 29c. LICENSE NUMBER D03599 | | 29d. DATE SIGNED (Month, Day, Year) 05-01-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John T. Bulkeley, M.D., Pine Bluff Road, Salisbury, Md. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 02 '90 | | | | 32. REGISTRAR'S SIGNATURE <i>Gerald E. Bounds</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal of the body. The law also requires that the death certificate be filed with the State Department of Health and Mental Hygiene within 72 hours after death with the State Department of Health and Mental Hygiene. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical certificate must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary Anna Brown | | | | 2. DATE OF DEATH MONTH 4 DAY 28 YEAR 90 | | 3. TIME OF DEATH 5:38PM | |
| 4. SOCIAL SECURITY NUMBER 216-18-8742 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 86 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 3 16 1904 | |
| 9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Easton | | 9c. COUNTY OF DEATH Talbot | |
| 10a. STATE Md | | | | 10b. COUNTY Talbot | | 10c. CITY, TOWN OR LOCATION Oxford | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER P.O. Box 111 | | 10f. ZIP CODE 21654 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Black | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Secondary College (1-4 or 5+) Teacher | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | | | | 16b. KIND OF BUSINESS/INDUSTRY | | 17. FATHER'S NAME (First, Middle, Last) Dan Batton | |
| 18. MOTHER'S NAME (First, Middle, Last) Annie Batton | | | | 19a. INFORMANT'S NAME (Type/Print) Nathaniel Brown | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 111 Oxford, Md. 21654 | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Richardson | | 20c. LOCATION — City or Town, State Easton, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bennie L. Smith | | | | 22. NAME AND ADDRESS OF FACILITY P.O. Box 928 Hurdock, Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Heart Disease Myocardial Infarct DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death year | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rheumatoid Arthritis Anemia of Chronic Disease | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Richard J. Mancuso MD | | | | 29c. LICENSE NUMBER 020829 | | 29d. DATE SIGNED (Month, Day, Year) 4/29/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 08 '90 | | | | 32. REGISTRAR'S SIGNATURE Richard J. Mancuso | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the attending physician, but the original must be filed with the funeral director, page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.



[Faint, illegible handwritten text]

90 13497

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) MAURICE E. BAKER | | | | 2. DATE OF DEATH MONTH May DAY 4 YEAR 90 | | 3. TIME OF DEATH 2 50 pm | |
| 4. SOCIAL SECURITY NUMBER 215-09-4138 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) FEB. 11, 1918 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) SUBURBAN HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA | |
| 9c. COUNTY OF DEATH MONTGOMERY | | | | 10a. STATE MARYLAND | | 10b. COUNTY MONTGOMERY | |
| 10c. CITY, TOWN OR LOCATION KENSINGTON | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3606 DUPONT AVENUE | |
| 10f. ZIP CODE 20895 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES KOREA | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ANALYST C.T.A. | | 16b. KIND OF BUSINESS/INDUSTRY FEDERAL GOVERNMENT | |
| 17. FATHER'S NAME (First, Middle, Last) FELIX K. BAKER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET C. KELLY | | | |
| 19a. INFORMANT'S NAME (Type/Print) CELESTE L. BAKER (WIFE) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3606 DUPONT AVENUE KENSINGTON, MARYLAND 20895 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GATE OF HEAVEN CEMETERY | | 20c. LOCATION — City or Town, State SILVER SPRING, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. lung cancer DUE TO (OR AS A CONSEQUENCE OF): b. tobacco smoking DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death one month more than 20 years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. coronary artery disease lymphoma (in remission) | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D33443 | | 29d. DATE SIGNED (Month, Day, Year) 4 May 90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Alan R Pollack, M.D. 809 Viers Mill Road Rockville, Md 20851 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 09 '90 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be used for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000



90 13498

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ALICE V. BROWN | | | | 2. DATE OF DEATH MONTH DAY YEAR MAY 7 1990 | | 3. TIME OF DEATH 12:45 PM | |
| 4. SOCIAL SECURITY NUMBER 718-14-0408 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) APRIL 4, 1903 | |
| 8. BIRTHPLACE (State or Foreign Country) Washington, D.C. | | | | 9. FACILITY NAME (If not institution, give street and number) MEDLANTIC MANOR NURSING HOME | | 10. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING | |
| 11. COUNTY OF DEATH MONTGOMERY | | | | 12. STATE MARYLAND | | 13. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 14. STREET AND NUMBER 3611 RALPH ROAD | | | | 15. ZIP CODE 20906 | | 16. CITIZEN OF WHAT COUNTRY? USA | |
| 17. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | | 18. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | |
| 20. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN | | | | 21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) RECORDS CLERK | | 22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ASSOC. AMERICAN RAILROADS | |
| 23. FATHER'S NAME (First, Middle, Last) JOHN McCLELLAN | | | | 24. MOTHER'S NAME (First, Middle, Maiden Surname) MARY KENNY | | | |
| 25. INFORMANT'S NAME (Type/Print) JEAN MAGEE (DAUGHTER) | | | | 26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3611 RALPH ROAD SILVER SPRING, MARYLAND 20906 | | | |
| 27. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 28. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GATE OF HEAVEN CEMETERY | | 29. LOCATION — City or Town, State SILVER SPRING, MARYLAND | |
| 30. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Francis J. Collins</i> | | | | 31. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL SPR, MD 20901 | | | |
| 32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): UREMIA DUE TO (OR AS A CONSEQUENCE OF): CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): CEREBRO VASCULAR ACCIDENT | | | | | | | |
| 33. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____ | | | | | | | |
| 34. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 35. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 36. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 37. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 38. DATE OF INJURY (Month, Day, Year) _____ | | 39. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 40. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) _____ | | | | 41. DESCRIBE HOW INJURY OCCURED _____ | | | |
| 42. LOCATION (Street and Number or Rural Route Number, City or Town, State) _____ | | | | 43. DATE SIGNED (Month, Day, Year) 5/7/90 | | | |
| 44. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 45. SIGNATURE AND TITLE OF CERTIFIER <i>Ernesto Malave</i> | | | |
| 46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ERNESTO MALAVE 12102 Georgina Ave Wheaton MD | | | | 47. LICENSE NUMBER D35362 | | | |
| 48. DATE FILED (Month, Day, Year) MAY 09 1990 | | | | 49. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE AND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 of 2 of this certificate must be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 13499

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HARVEY R. BROWN JR. | | | | 2. DATE OF DEATH MONTH 4 DAY 19 YEAR 1990 | | 3. TIME OF DEATH 2:00P M | |
| 4. SOCIAL SECURITY NUMBER 214-18-9203 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-11-1922 | |
| 8a. FACILITY NAME (If not institution, give street and number) 529 N. DECKER AVE. | | | | 8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 8c. COUNTY OF DEATH MD. | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 529 N. DECKER AVE. | | | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WORLD | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 11TH College (1-4 or 5+) 1 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) INSPECTOR | | 16b. KIND OF BUSINESS/INDUSTRY FOOD SERVICE | | | |
| 17. FATHER'S NAME (First, Middle, Last) HARVEY P. BROWN SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CATHERINE DOERER | | | |
| 19a. INFORMANT'S NAME (Type/Print) JOANNE J. BROWN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 529 N. DECKER AVE. BALTO. MD. 21205 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ST. STANISLAUS CEM. | | 20c. LOCATION — City or Town, State BALTO. MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas J. Spaulding | | | | 22. NAME AND ADDRESS OF FACILITY SKARDA F.H. 2829 HUDSON ST. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CANCER - METASTATIC TO BIAN Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> lung Cancer lung Cancer lung Cancer lung Cancer </div> <div style="width: 60%;"> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. </div> </div> | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. J. S. [Signature] | | | | 29c. LICENSE NUMBER D 24276 | | 29d. DATE SIGNED (Month, Day, Year) 4-23-90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2900 S. BALTO. ST. BALTO. MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 24 '90 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 13500

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Katherine A BUSH | | | | 2. DATE OF DEATH MONTH DAY YEAR April 21, 1990 | | 3. TIME OF DEATH 11:15 P M | |
| 4. SOCIAL SECURITY NUMBER 219-18-4269 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 66 YRS. | 7. DATE OF BIRTH (Month, Day, Year) AUG. 25, 1923 | | 8. BIRTHPLACE (State or Foreign Country) MD. | |
| 9a. FACILITY NAME (If not institution, give street and number) FRANKLIN Sq. Hosp. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE MD. | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION ROSEDALE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 9223 RAVENWOOD RD. | | | | 10f. ZIP CODE 21237 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECURITY CLERK | | 16b. KIND OF BUSINESS/INDUSTRY FEDERAL GOV. | | | |
| 17. FATHER'S NAME (First, Middle, Last) FREDERICK SCHEUFEL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA SHRYOCK | | | |
| 19a. INFORMANT'S NAME (Type/Print) HUNTER E. BUSH | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9223 RAVENWOOD RD. BALTO. MD. 21237 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) HOLLY HILL CEM. | | 20c. LOCATION — City or Town, State BALTO. CO. MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas J. Skarda Jr. | | | | 22. NAME AND ADDRESS OF FACILITY HOFFMAN-SKARDA 3218 HUDSON ST | | | |
| 23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lupus Encephalopathy DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Status Epilepticus DUE TO (OR AS A CONSEQUENCE OF): c. Metastatic Acidosis DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER S. Khoromi | | | | 29c. LICENSE NUMBER N/A | | 29d. DATE SIGNED (Month, Day, Year) 4/21/90 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Suzan Khoromi MD 9000 Franklin Square Drive 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) APR 24 '90 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

